Real Patients as Co-debriefers in Simulation-Based Education: An exploratory study

by

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Abstract

This thesis explores and describes the experiences and perspectives of three different roles within a patient-centred, healthcare simulation-based education session for the continuing professional development of new graduate nurses. The experiences examined are those of the session's co-debriefers, who include a mix of patient family partners and clinical educators, and the learners, who are new graduate nurses. The study uses mixed methods but primarily takes the form of a basic qualitative descriptive study and meets the requirements of patient-oriented research. Participants included 44 new graduate nurses, six clinical educators, and two patient family partners. Survey and interview analysis are developed around three main themes: *Findings specific to simulation and co-debriefing*, *Beliefs surrounding patient- and family-centred care and the inclusion of patient family partners,* and *Relationships*. Implications for practice and future research are recommended.

Keywords: simulation; co-debriefing; patient-centred simulation; patient- and family-centred care; patient and family engagement; patient engagement; patient-oriented research; continuing professional development

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Glossary

Simulation	“A technique that creates a situation or environment to allow persons to experience a representation of a real event for the purpose of practice, learning, evaluation, testing, or to gain understanding of systems or human actions.” (Lioce et al., 2020, p. 44)
Debriefer	“The individual who facilitates a debriefing session and is knowledgeable and skilled in performing appropriate, structured, and psychologically safe debriefing sessions (Fanning & Gaba, 2007 as cited in (Lioce et al., 2020, p.14)
Co-debriefing	When two or more educators facilitate a debriefing together (Cheng et al., 2015)
Simulated Patient	“A person who has been carefully coached to simulate an actual patient so accurately that the simulation cannot be detected by a skilled clinician.” (Lioce et al., 2020, p. 43)
New Graduate Nurse	A nurse who has recently graduated from nursing school; the period of time during which a nurse qualifies as a “new grad” is anywhere between 12 to 36 months after graduation (Edwards, Hawker, Carrier, & Rees, 2015; Jewell, 2013; Pasila, Elo, & Kääriäinen, 2017)
Patient Family Partner	Someone who has sustained, lived experience of the healthcare system as a patient or a patient’s main caregiver or representative. They are advocates and experts in the patient/family experience of healthcare.
Clinical Educator	A healthcare professional who plans, develops, implements and evaluates education related to clinical content for other healthcare professionals or students.

Chapter 1. Introduction

Historically (and arguably to this day), there exists a power differential and hierarchy between patients and clinicians in the healthcare system, whereby clinicians are seen as experts of medicine and patients as passive recipients of the care related to clinician knowledge. More recently, there has been a shift towards patient- and family-centred care, whereby patients and their families are seen as equal partners within the healthcare system and as the experts of their experience of illness (Ocloo, Josephine; Matthews, 2016). This is an important shift in how care is provided as it "ensures they [patients and families] retain control over their own choices, helps them make informed decisions and supports a partnership between individuals, families, and health care services providers" (British Columbia Ministry of Health, 2015, p. 1).

An avenue through which patient- and family-centred care could be applied to flatten this hierarchy is within the realm of simulation-based education. Simulation-based education in healthcare – often referred to simply as "simulation" – has proliferated in use over the last 30 years (Gaba, 2007). The Healthcare Simulation Dictionary (2016) defines "healthcare simulation" as "a technique that creates a situation or environment to allow persons to experience a representation of a real healthcare event for the purpose of practice, learning, evaluation, testing, or to gain understanding of systems or human actions" (p.14).

Drawing from Kolb's (1984) original Experiential Learning Theory (Fanning & Gaba, 2007; Poore, Cullen, & Schaar, 2014), simulation has three distinct phases:

1. Orientation. Where participants learn the rules of the simulation which will follow.
2. Scenario. When the actual simulation takes place.
3. Debrief. A guided process of refection and discovery related to the events which occurred during the simulation.

A facilitator, often commonly understood as a teacher or instructor, is present throughout this process. The facilitator's objective is to act as a "guide on the side" for participants and help steer simulation participants towards meaningful reflection, discovery, and learning (Fanning & Gaba, 2007). Facilitators also "assume responsibility

and oversight for managing" the simulation and therefore require skills and abilities specific to this role (INACSL Standards Committee, 2016b, p. S16). Though the facilitator role has historically been occupied by healthcare clinicians, there are rare instances when patient and family partners share this responsibility (Arnold, McKenzie, Miller, & Mancini, 2018; Díaz-Agea et al., 2017). The potentials this may have are aligning healthcare education with patients' goals, increasing the awareness of healthcare professionals to the patient perspective, and incorporating the patient perspective and patient- and family-centred care principles into clinical decision-making.

Applying patient- and family-centred care to the realm of simulation is an emerging endeavour. In 2018, a descriptive article summarizing the findings of a group of healthcare simulation research experts found that at the time, no consensus existed on what "patient-centred simulation encompasses" (Arnold et al., 2018, p. s51). In relation to patient-centred simulation, it was recommended that "…the time is now to research and define best practice, evaluate impact on outcomes, determine feasibility and costs, and lastly evaluate for potential adverse effects." (p. s55)

In one local health authority's hospitals in Metro Vancouver, patient-centred simulation takes place within a full-day workshop targeted at new graduate nurses. As part of the team who created and delivered this workshop, the researcher saw an opportunity to help fill the knowledge gap related to patient-centred simulation. As such, this study seeks to explore and describe the experiences and perspectives of three different participant types within a clinical educator and patient family partner co-facilitated simulation session for new graduate nurses. Research questions pursued in this study are:

- How do members from each role within a new graduate nurse clinical decision-making workshop describe the experience of working in a program with patient-centred simulation?
    - What are the perceived benefits and risks of working with, or of being, patient family partners in simulation-based education?
    - How do members within each role perceive the value of patient family partners in simulation-based education, both at large and within the narrower, lived experience of a new graduate nurse clinical decision-making workshop?
    - Are there similar findings between roles and if so, what are they?

- How do members from each role perceive the relationship between roles?

Chapter 2. Background

2.1. Simulation-based Education

Simulation-based education has long been used as a method for training and learning throughout a variety of fields. These include the military, aviation, aeronautics, and medicine (Fanning & Gaba, 2007; Halamek & Cheng, 2017; Kikkawa & Mavin, 2017; Sawyer, Eppich, Brett-fleegler, Grant, & Cheng, 2016). Simulation-based education is founded upon Kolb's (1984) theory of Experiential Learning. Both place experience as central in human learning and development, with a complementary focus on guided post-event reflection (Fanning & Gaba, 2007; Lederman, 1992; Poore et al., 2014; Sawyer et al., 2016; Zigmont, Jason J., Kappus, Liana J., and Sudikoff, 2011). Simulation-based education also aligns with principles of Guided Discovery Learning, whereby learners are placed in a discovery environment with an instructor who is available to help guide learning via coaching, feedback, hints, and/or modeling (Mayer, 2004).

The debrief is an essential component of simulation-based education (INACSL Standards Committee, 2016a). The debrief portion of a simulation-based education event can be described as "...a discussion between two or more individuals in which aspects of a performance are explored and analysed with the aim of gaining insights that impact the quality of future clinical practice" (Cheng et al., 2014, p. 658). Debriefing is a critical component of learning in simulation and is necessary to facilitate change "on an individual and systematic level" (Dieckmann, Molin Friis, Lippert, & Ostergaard, 2009, p. e287).

The debriefing facilitator, also known as the debriefer, is typically an experienced healthcare professional who also has simulation and subject matter expertise (INACSL Standards Committee, 2016b). During interprofessional simulation-based education, whereby participants are from different disciplines and learn from, with, and about one another (CAIPE, 1997), it is recommended that interprofessional co-debriefing occur to role model interprofessional education (Andersen et al., 2018; Brown et al., 2018).

This model of co-facilitation or co-debriefing in simulation-based education is ripe for the incorporation of patient- and family-centred care. There have been calls, although

few, to highlight the patient voice in simulation (Arnold et al., 2018; Nestel & Kneebone, 2010; Park & Holtschneider, 2016). Using Arnold et al.'s (2018) suggested terminology for patient-centred simulation, the use of patients and family as co-debriefers would fall under the category of "patient-directed simulation." Patient-directed simulation is described as "the use of authentic patient 'voices' to create healthcare-related simulations…targeted at enhancing the patient experience, increasing the level of patient engagement, and improving patient care outcomes" (Arnold et al., 2018, p. s51).

While there exists a large number of published studies describing the use of simulated or standardized patients in medical training (Barrows, 1968; Lewis et al., 2017; Nestel et al., 2010; Plaksin et al., 2016; Williams & Song, 2016), few pertain to the use of real patients as co-facilitators in simulation for continuing professional development. (The difference between real patients and simulated patients – who are often actors employed within a simulation scenario – will be given more consideration in section 3.2.1.) Examples which exist include "an emerging collaboration in Minnesota, USA, between healthcare staff and patient partners," highlighted in Arnold et al.'s (2018) paper (p. s52). As described there, the collaboration is between healthcare staff and patient partners who will work together to develop simulation cases, learning objectives, debriefing prompts, and identify future areas of research, as well as participate together in debriefing and/or feedback sessions for learners. The learners will be healthcare students and residents, as well as other patients and families. No other information about this project has yet been published.

The only other example of a patient-directed simulation study the author identified in the literature is from a School of Nursing in Spain, where the use of real patients as co-debriefers is employed (Díaz-Agea et al., 2017). In a mixed methods study, the authors strove "to assess the impact of including real patients as co-debriefers in clinical simulations with fourth year nursing students on students' perceived learning, empathy, satisfaction, and debriefing effectiveness" (p. 406); as such, it is somewhat similar to the research this paper explores. Main findings from that study were that the inclusion of patients as co-debriefers had a positive impact on both student and patient participants in all study categories (learning, empathy, satisfaction, and perceptions of the debriefing); students found the experience with the patients "an enriching learning experience" (Diaz-Agea et al., 2017, p. 408); the co-debriefing between the nursing teacher and the patient was complementary of each other's feedback; the personal

experience of the patient became the highlight of the learning; having a patient present reinforced the notion of patients and healthcare professionals as a collaborative team; and the presence of a patient in the debriefing brought forth feelings of empathy and compassion from the students (Díaz-Agea et al., 2017).

2.2. Patient- and Family-Centred Care; Patients as Teachers

Originally termed “patient-centred medicine” by Balint et al. in the late 1960’s (Balint, 1969), patient- and family-centred care has evolved from focusing solely on how patients and families *define* the quality of care in hospitals to the current four core, action-based concepts (Conway et al., 2006). These four core concepts, originating from the American Hospital Association (American Hospital Association & Institute for Family-Centered Care, 2004) and endorsed by the Institute for Healthcare Improvement (2020) are: Dignity and Respect, Information Sharing, Participation, and Collaboration. The Institute for Patient- and Family-Centered Care describes the four core concepts as such:

> **Dignity and Respect**. Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care.
>
> **Information Sharing**. Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
>
> **Participation**. Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
>
> **Collaboration.** Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation, and evaluation; in facility design; in research; and in professional education, as well as in the delivery of care (Institute for Family-Centered Care, 2017).

These can be achieved by: actively calling for and listening to patient and family beliefs, values, and perspectives and incorporating these into care; healthcare personnel sharing information with patients and families in a transparent and unbiased fashion, in a timely manner; allowing patients and families to be as involved as they so choose in all

aspects of care; and including patients and families to have a voice through collaboration throughout the differing levels of healthcare (American Hospital Association & Institute for Family-Centered Care, 2004). Ultimately, the core concepts call for healthcare personnel to promote and support the inclusion of patients and families as equal partners in healthcare at the experience, quality improvement, organization, and policy and program development levels (Conway et al., 2006). Despite these recommendations, the incorporation of patient- and family-centred care into continuing professional development – versus academic and student teaching – remains rare (Cox, Cuff, Brandt, Reeves, & Zierler, 2016; Towle & Godolphin, 2013).

In the 2008 report, “Partnering with Patients and Families to Design a Patient- and Family-Centered Health Care System,” an entire chapter is dedicated to how to incorporate patient- and family-centred care (also known as patient and family engagement) into educating health care professionals (Johnson, Abraham, & Conway, 2008). Included in the key recommendations is the involvement of patients and families in the development, implementation, and review of continuing professional development programs for healthcare professionals. The report includes one example of an initiative specifically tailored for new graduate nurses, as well as two other examples for nurses at large. In all instances, education delivered by patients and families was consistently rated very favourably by a high majority of attendees (Johnson, Abraham, & Conway, 2008, pp. 55, 57).

The concept of patients and families as teachers for healthcare professionals is not new. Since the 1960’s, patients have been employed to assist in healthcare professional teaching - mainly in the field of medical education (Barrows, 1968). The term *patient* is defined as, “someone with experience of a disease, either personally or as a result of looking after someone with the disease” (Jha, Quinton, Bekker, & Roberts, 2009a, p. 11). Patients who teach in healthcare professional education are most often referred to as *patients as teachers* (Stacy & Spencer, 1999; Wykurz & Kelly, 2002), *patient-teachers* (Jha, Quinton, Bekker, & Roberts, 2009b), or *patient-instructors* (Henriksen & Ringsted, 2011; Jha et al., 2009b).

When patient-teachers are seen as knowledgeable partners who can share their own experiences and are treated as experts in their respective conditions, patients as

teachers have been shown to produce many benefits. These can be categorized as follows:

- **Benefits to learners and patient- teachers**. Patient-teachers have a positive influence on both learners and patients (Haq, Fuller, & Dacre, 2006; Humphrey-Murto, Smith, Touchie, & Wood, 2004; Jackson, Blaxter, & Lewando-Hundt, 2003) and contribute to an increased sense of collaboration and partnership between patients and healthcare staff (Jha et al., 2009a, 2009b; Stacy & Spencer, 1999; Thistlethwaite & Cockayne, 2004). This education methodology also provides a chance to demonstrate equal partnership between patients and healthcare personnel (Jha et al., 2009b). It has also been reported that participating in co-faciliated patient-clinician education has resulted in a greater sense of empathy from healthcare professionals towards patients (Díaz-Agea et al., 2017).

- **Benefits to learners**. Working with patients as teachers allows learners to experience meaningful, experiential, lived storytelling surrounding the psychological, social, emotional, and financial impacts of illness and consolidation of theory (Díaz-Agea et al., 2017; Henriksen & Ringsted, 2011; Jha et al., 2009b, 2009a).

- **Benefits to patients.** Those who have been patient-instructors have described empowerment and enhanced self-esteem through this activity (Benson, Quince, Hibble, Fanshawe, & Emery, 2005; Chur-Hansen & Koopowitz, 2004; Haq et al., 2006; Jha et al., 2009b; Plaksin et al., 2016).

- **A positive influence on the learning environment.** Learners who interact with patient-instructors cite increased authenticity and intimacy in the learning environment (Henriksen & Ringsted, 2011) and feel as though they are learning from patients in a safe environment (Haq et al., 2006; Hendry, Schrieber, & Bryce, 1999; Henriksen & Ringsted, 2011; Raj, Badcock, Brown, Deighton, & O'Reilly, 2006);

Challenges also exist. Feelings of anxiety, vulnerability, nervousness, and a sense of being exposed on the part of the patient are common (Coleman & Murray, 2002; Jha et al., 2009a; Lauckner, Doucet, & Wells, 2012; Towle & Godolphin, 2013). Often the use of patients as teachers is seen as "tokenistic," whereby students have the perception that patients are employed solely as a requirement to "tick off a box" and not used effectively for teaching (Jha et al., 2009a, p. 452).

Despite the existence of patient-teachers for over 50 years, its uptake and use as a teaching methodology has, to date, not been widely embedded throughout continuing professional development curricula. This is particularly so at the health delivery and health professional levels (versus academic and student education). A 2015 report concerning interprofessional education (IPE) from the Institute of Medicine states that,

> At the present time, education and health system leaders generally fail to consider the importance of workplace learning as an effective means of promoting collaborative practice… the inclusion of patient, family, and caregiver experiences could be especially helpful in promoting better alignment between education and practice as well as for impacting person- and community-centred outcomes (Cox et al., 2016, pp. 2–3).

Even more specifically, there is very little research dedicated to the incorporation of patients with a lived experience of illness and recipients of care within the healthcare system – hereto referred to as *real* patients or patient family partners – as teachers within simulation-based education for continuing professional development.

2.3. New Graduate Nurses

A “new graduate nurse” is any nurse who has recently graduated from nursing school; the period of time during which a nurse qualifies as a “new grad” is anywhere between 12 to 36 months after graduation (Edwards, Hawker, Carrier, & Rees, 2015; Jewell, 2013; Pasila, Elo, & Kääriäinen, 2017). The target audience for the simulation-based education in this study were new graduate nurses. A large body of literature surrounding new graduate nurses exists, with particular regard to the transition of nurses from student to professional. Globally, this transition has been described as incredibly stressful, with large numbers of new graduate nurses leaving the profession (Edwards et al., 2015; Jewell, 2013; Jung, Lee, Kang, & Kim, 2017; Laschinger et al., 2016; Pasila et al., 2017; Rush, Adamack, & Gordon, 2013). As summarized by Edwards et al. (2015), “A variety of support strategies to improve the transition process [for new graduate nurses] have been reported in the international literature” (p.1255). Simulation-based education is one of these strategies.

Chapter 3. Methodology

3.1. Research Design

This study uses mixed methods, but primarily takes the form of a basic qualitative descriptive study (Kim, Sefcik, & Bradway, 2017; Sandelowski, 2000). Notably, this study is guided by the principles of Patient Oriented Research, a relatively new field led by the Canadian Institutes of Health Research (Canadian Institutes of Health Research, August 2011).

3.1.1. Qualitative Approach

Basic qualitative descriptive study

Similar to what is often termed “basic qualitative research” (Merriam & Tisdell, 2016, p. 23), basic qualitative descriptive studies are often employed in applied fields of practice, seek to provide “a comprehensive summary of events in the everyday terms of those events” (Sandelowski, 2000, p. 334). They are primarily seen as either gateways to further study or as end-products unto themselves. This type of research aligns well with this study, which is situated in the field of nursing continuing professional development and is intended as an entry point to further study of the inclusion of patients as co-debriefers in patient-centred simulation within the healthcare continuing professional development landscape.

Unlike other forms of qualitative research such as grounded theory or phenomenology, basic qualitative description does not require researchers to commit their study to a pre-existing theoretical and/or philosophical stance (Sandelowski, 2000). Rather, it asks only that researchers use naturalistic inquiry to employ techniques which will “allow the target phenomenon to present itself as it would if it were not under study” (p. 337). Although this study does draw heavily from the theory of patient- and family-centred care, it does not presuppose patient- and family-centred care as a “source of truth” or as a fully established tenet. This study genuinely seeks to inquire, without assumption or judgment.

Other qualitative research methodology considerations

There are portions of the study's methodology which draw from phenomenology. Though the study does seek to understand how participants experience and perceive their roles within a phenomenon (Merriam & Tisdell, 2016), it does not attempt to explain how this experience is transformed into consciousness. The study also did not presuppose that an "essence" – "a structure of essential meanings that explicates a phenomenon of interest" (Dahlberg, 2006, p. 11) - between participants would be evident, though the author was open to its possibility. Despite this openness, no essence was found.

In alignment with phenomenological principles the author attempted to achieve "epoché" by bracketing her own biases and beliefs when conducting the study. This was done by employing similar techniques as when debriefing: thoughtful and active listening, withholding judgment, having genuine curiosity, holding space and having a high regard for others. As the author has had roles similar to those under study, this was an important step.

3.1.2. Patient-Oriented Research

Patient-oriented research is a relatively new approach to medically oriented research in Canada; the Canadian Institutes of Health Research developed the seminal "Canada's Strategy for Patient-Oriented Research" document in August of 2011. This document outlines the strategy and vision of patient-oriented research in Canada, stating that,

> The vision of the Strategy for Patient-Oriented Research is to demonstrably improve health outcomes and enhance patients' health care experience through integration of evidence at all levels in the health care system. (Canadian Institutes for Health Research (CIHR), 2011, p. 5)

Strategies to fulfill this vision include addressing "the gaps in the research-to-practice continuum, including…The limited role of patients in patient-oriented research" (CIHR, 2011, p. 6), and acting on the knowledge that "there is growing support for the view that health research needs to assess interventions and outcomes considered important by patients" (CIHR, 2011, p. 9).

Regrettably, there are currently no agreed-upon theoretical frameworks for the inclusion of patients as partners – or what Black et al. have coined the "patient research partner" (2018) – in health research (Manafo, Petermann, Mason-Lai, & Vandall-Walker, 2018). To guide the present study, a number of journal articles and locally developed resources were referenced, along with guidance from the British Columbia Support for People and Patient-Oriented Research and Trials (BC SUPPORT) unit. The BC SUPPORT unit is a branch of the Canadian Institute for Health Research and was developed with the goal of advancing patient-oriented research (BC SUPPORT Unit, 2020).

As is recommended, potential patient research partners were recruited through a patient engagement network's newsletter (CIHR, 2011). Multiple individuals were interested in the position and so brief interviews were held. These interviews reviewed the research proposal, author and potential patient research partner values and reasons for wanting to conduct the study, working relationship values, foreseeable levels of participation and time commitments, preferred workstyles and modes of feedback, previous applicable experience, and compensation. These areas of review and proposed values reflected Black et al.'s (2018) suggestions of creating an open and positive team atmosphere, having a respectful working relationship, clearly defining roles and expectations, ensuring patient research partners have access to study results, and providing compensation. About halfway through the project, the "Workbook to guide the development of a Patient Engagement in Research (PEIR) Plan" (The PEIRS Project Team, 2018) – was used as a "check-in" between the patient research partner and author to ensure the research team still had a mutual understanding of the members' level of engagement and the research process. The PEIR plan guides research teams to review and discuss eight components which "collectively contribute to meaningful patient engagement in research" (The PEIRS Project Team, 2018, p. 5) including: procedural requirements, convenience, contributions, support, team interaction, research environment, feeling valued, and benefits.

Given that only ten percent of all patient-oriented research studies which include patient research partners participate throughout the research process (Manafo et al., 2018), the author wanted to ensure that patient-oriented research principles were applied throughout the study. Patient engagement throughout the project was guided by the International Association for Public Participation (IAP2) Spectrum of Public

Participation (2018), which delineates participation levels as per the below. Please note that the original Spectrum uses the word “public” to describe community engagement. For the purposes of this study, all instances of the word “public” have been changed to “patient,” as patient-oriented research – and the study team – value and emphasize the need for inclusion of the *patient* lens – those who have lived experience of the healthcare system in a sustained and meaningful manner. The difference between *citizen* participation and *patient* participation has been delineated and explained in texts such as the CIHR Jargon Buster (Canadian Institutes for Health Research (CIHR), 2020). Do note however, that this difference is not internationally recognized or agreed upon (Kaplan et al., 2013) and as this study finds, can lead to confusion amongst those within healthcare.

According to a widely used model developed by the IAP2, patient participation levels are as follows:

> **Inform:** To provide the patient with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.
>
> **Consult:** To obtain patient feedback on analysis, alternatives and/or decisions.
>
> **Involve:** To work directly with the patient throughout the process to ensure that public concerns and aspirations are consistently understood and considered.
>
> **Collaborate**: To partner with the patient in each aspect of the decision including the development of alternatives and the identification of the preferred solution.
>
> **Empower:** To place final decision making in the hands of the patient. (IAP2 International Federation, 2018)

The following table illustrates the level of patient engagement during key points in this study:

Table 3-1. Level of patient engagement throughout study

Research step	Level of engagement
Research problem	Consult
Research question	Collaborate
Research design	Consult
Data collection: general	Collaborate
Data collection: patient interviews	Empower
Data analysis: general	Consult
Data analysis: patient participants	Collaborate
Study findings and validation	Patient research partner: Consult Patient participants: Consult

3.1.3. Mixed Methods

A survey was conducted with all participants to support triangulation during data analysis, as well as to provide avenues for both private and social (through focus group interviews) sharing.

The survey (see Appendix A for New Graduate Nurse Survey and Appendix B for Patient Family Partner and Clinical Educator Survey) consisted of eight Likert-scale questions, three open-ended questions, and one blank space for respondents to provide an artistic representation of the experience in question. As described, the survey involved both qualitative and quantitative data collection. As “data obtained from a focus group is socially constructed within the interaction of the group” (Merriam & Tisdell, 2016, p. 114), there was a chance that not all participants would feel as independent or free to voice their perspectives through focus groups alone. The survey was intended to remove this possible barrier and to provide a more broad-based set of data from which to understand participants’ experiences.

The Likert scale questions, many of which mirror Díaz-Agea et al.’s (2017) survey of nursing students’ perceptions of patients as co-debriefers, were included with the aim of triangulating the qualitative findings. Qualitative findings were obtained through focus group interviews and open-ended survey questions. The blank space in which to draw a depiction of the experience was included for those who might have an easier time expressing themselves through a form other than words.

3.2. Research Context

Participants in this study were recruited from the previously mentioned New Graduate Nurse workshop. The full-day workshop, which takes place in Metro Vancouver, British Columbia, Canada, is designed to have two main components: theory and practice. Theoretical understanding and paper-based application of the Situated Clinical Decision-Making framework (Gillespie, 2010) takes place during the morning of the workshop. This is followed by real-time practice and application of the framework within two different simulation-based education scenarios in the afternoon.

The learners registered for this course are nurses of varied backgrounds: Registered Nurses, Registered Psychiatric Nurses, and Licensed Practical Nurses. They work in a variety of practice settings, from community to acute. The first half of the workshop is led by a clinical educator, who is a nurse. The patient-centred simulation portion of the workshop continues to be led by the same clinical educator but also includes patient family partners as co-debriefers, actors as simulated patients, and another clinical educator to facilitate concurrent education sessions (see Appendix C for a detailed description of how the workshop's simulation-based education sessions are coordinated).

Note that prior to participation in the workshop, patient family partners and clinical educators had been oriented to simulation-based education and equipped with tools for co-debriefing. Both groups had attended a one-day co-debriefing workshop tailored specifically to participation in this workshop and clinical educators had, at minimum, an additional two full days of simulation-based education and debriefing practice.

An overview of the four different roles involved in the patient-centred simulation follows:

1. The new graduate nurses are participants throughout the simulations. In each scenario (see Appendix C), 2-4 of the new graduate nurses actively participate in the simulation while the remainder act as observers. Active participants in the simulation scenario are chosen either on a first-come, first-served volunteer basis. If there are no volunteers, active participants are

determined by drawing straws. All new graduate nurses are invited to be active participants in the debrief portion of the simulation.

2. The clinical educators act as the main facilitators of the simulation-based education activities. In each simulation scenario (of which there are a total of two), there is one clinical educator who coordinates the intersection of the four different role groups participating. This educator also facilitates the pre-brief and running of the simulation scenario. They then co-debrief with the patient family partner. (See Appendix C)

3. The patient family partners are observers of the simulation scenario and co-debrief the new graduate nurses with the clinical educator after the scenario has concluded. How the co-debriefing occurs is not scripted but rather left to the clinical educator and patient family partner to decide through one on one discussion. Though a “co-debriefing checklist” was originally provided to review between the patient family partner and healthcare educator prior to the simulation, this was quickly abandoned. From what clinical educators described, this was either due to a lack of time during the workshop or because the co-debriefers had worked together enough times previously to develop an established rapport and style between them (see sections 4.1.2., 5.1.1., and 6.1.).

4. The simulated patients are actors who portray patients during the simulation scenario. These are paid actors who follow a guided script and scenario objectives. Note that in this text the term “simulated patient” is purposefully used instead of “standardized patient”. As highlighted in the 2nd Edition of the Healthcare Simulation Dictionary (2020), though the terms “simulated patient” and “standardized patient” are often used interchangeably, a “…simulated patient (SP) is considered a broader term than standardized patient, because the simulated patient scenario can be designed to vary the SP role in order to meet the needs of the learner” (p. 43). This is the intent in the New Graduate Nurse workshop; the purpose of the simulated patients is to increase the realism of the scenario for the new graduate nurses who are participating, by providing real-time responses, emotions, and cues during the scenario. Simulated patients participate in the debrief but have been instructed to

answer questions or provide feedback only when invited to do so by the co-debriefers. This is done to direct patient-related questions to the patient family partner, as opposed to the simulated patients who are classified as *citizens* and not *patients* (details in Table 3-1, below). Simulated patients have not been instructed as to whether to stay in character during the debrief.

3.2.1. Simulated patients and real patients

As outlined above, the simulation activities experienced by the participants of the new graduate nurse workshop employ two different types of "patients"– the simulated patients in the scenario who are actors, and the patient family partners who observe the scenario and co-debrief after the scenario is over. Both types of "patients" are present in the debrief, and both give their feedback to the participants. The main differences between the two are outlined in the following table:

Table 3-2. Simulated Patients and Patient Family Partners

	Simulated Patient	Patient Family Partner
Profession	Actor	May be from a variety of professional backgrounds, or unemployed, retired
Level of healthcare interaction	May or may not have had significant experience with the healthcare system	Has had significant, sustained, lived experience and interaction with the healthcare system as a patient, patient's family member, or as the primary caregiver of a patient
Recruitment for simulation activity	Recruited through a Simulated Patient program	Recruited through an organization specific to the promotion and inclusion of patient and family engagement in healthcare
Purpose of inclusion in simulation activity	Primary: Increase all types of fidelity for learners during simulation scenario Secondary: Provide feedback to learners (unspecified whether to stay in character)	Primary: Provide feedback to participants from the authentic perspective of a patient and family partner; promote patient- and family-centred care

While there exists a wide body of literature describing the benefit of simulated patients in simulation scenarios (Williams & Song, 2016) as well as a separate body of literature promoting patients as teachers (Towle et al., 2010), there is no previous literature pertaining to the inclusion of both types of patients within a simulation activity from which to draw.

Though comparison of the two types of patients was not originally a main feature of this study, it is explored in the "Findings," "Discussion," "Implications for Practice" and "Considerations for Future Research" chapters, as role confusion and overlap between these two types of "patients" was seen in the data.

3.3. Participants

Access to potential research participants was granted by the director and manager overseeing the new graduate nurse workshop. Recruitment for this study was done in different ways for the three separate groups of participants, either through face-to-face requests or by email.

3.3.1. Clinical Educator and Patient Family Partner recruitment

Due to the small number of eligible clinical educators and patient family partners – eight in each group for the new graduate nurse workshop – all were invited to participate in the study. Eligibility criteria for these groups consisted of:

- Having co-debriefed in the simulation portion of the New Graduate Nurse workshop
- Currently living within the Metro Vancouver area

The second criterion was originally established for interviewers' ease of access to participants for face-to-face interviews. However, as described in the "Limitations" section of this paper, telephone interviews were ultimately conducted for some participants to increase the convenience of participating for interviewees.

All potential clinical educator and patient family partner participants were informed of the study through e-mail. Initial e-mail contact for the clinical educators was done in May of 2019 by the author, who had an established collegial rapport and easy access and face-to-face contact with, these potential participants. Patient family partner participants were initially emailed in May of 2019 but due to challenges and personnel changes within the research team, patient family partner participants were not recruited at that time. They were emailed again in November of 2019, and once again in January 2020 due to low recruitment numbers. In all instances, emails were sent by an administrative assistant with both the author and patient research partner copied on the

e-mail. The author did not email the participants directly due to her involvement with the New Graduate Nurse workshop and her position as a clinical educator; this was done to avoid any perception of pressure on the patient family partners to participate in the research. Similarly, patient family partners were given the option of continued communication via the patient research partner – without the author – in order to increase anonymity and to reduce the perceived pressure to participate in the research.

3.3.2. New Graduate Nurse Recruitment

As the workshop from which participants were recruited was held once a month and open to registration for all new graduate nurses in the health authority, there was a large sample from which to draw. Because of this, new graduate nurses were recruited using a non-randomized, convenience sample. In this study, the limiting factors which led to a convenience sample were time and location – there was a limited amount of time during which to recruit. To maximize efficiency, new graduate nurses were interviewed immediately after their attendance at a workshop.

Ultimately, new graduate nurses were recruited from three workshops conducted over the course of three months. Workshops were held across two different sites. All new graduate nurses who participated in the simulation portion of the workshop over the three-month recruiting period were invited to participate. Recruitment was carried out at the workshop itself, immediately before the simulations were to begin in a face-to-face, group announcement by the author. The announcement included a brief description of the study, types of participation, the need for consent, the ability to withdraw from participation at any time prior to the end of the study, and emphasized the voluntary nature of participation (see Appendix D).

3.4. Data Collection

Prior to recruitment and data collection, ethical clearance was obtained through the Research Ethics BC Provincial Research Ethics Program. This was required as Christina was completing the research as part of this thesis for Simon Fraser University, but the research participants were from a different institution, which resulted in a multi-jurisdiction study. After a harmonized review – whereby each involved jurisdiction's

institutional research ethics board has reviewed the study (Simon Fraser University, n.d.) – the study was approved.

Potential participants were provided with a study consent form and given time to read it through prior to deciding whether to participate. If interested, participants were given the option of participating via a survey, interview, or both. Prior to interviews, participants were verbally reminded of the ability to withdraw from the study at any time prior to the study's completion. After findings were documented, the author individually e-mailed all research participants the documented findings and highlighted any direct quotes they had contributed. Participants were asked to contact the author if they believed their remarks were misrepresented and/or if they would like to have their quotes omitted.

None of the participants requested that their remarks be withdrawn. Any surveys which were submitted without fully completed consent forms were discarded confidentially. Where possible, surveys were collected and reviewed prior to interviews to allow interviewers insight into possible themes or areas to explore during real-time interviews.

While the use of real patients as co-debriefers is a new phenomenon with little reported data, it may be similar to other iterations of patients as teachers. Because of this, we chose a semi-structured approach to allow for flexibility when exploring perspectives with participants while including specific questions about themes reported in the broader patients as teachers literature. An interview guide with a mix of broad and more specific questions (see Appendix E) was supplied to interviewers, who could incorporate follow-up questions as needed, based on participants' responses (Merriam & Tisdell, 2016).

As previously described, clinical educator interviews were a mix of focus groups and one-on-one interviews, dependent upon participant availability. All clinical educator interviews and focus groups were completed in the same city, by the author, over the period of one month. One-on-one interviews were approximately half an hour in length, whereas the focus group interview was an hour long.

New graduate nurse interviews were all focus groups with a minimum of three and a maximum of seven participants each. Interviews lasted between six and sixteen minutes, and all were completed by the same interviewer (the author).

All traditional healthcare and new graduate nurse interviews were similar in that the interviewer often asked for clarification, further description, or examples of general statements given. What participants shared was often recapped or rephrased by the interviewer, who then asked for verification from participants as to whether the interviewer's understanding of the comments was correct. Additional questions were sometimes posed by the interviewer when participants brought up points the interviewer thought may be worth further exploration.

Patient family partner interviews were completed over a period of one week and all were done in a one-on-one, telephone format for ease of scheduling and convenience for the participants. All interviews were completed by the patient research partner and lasted approximately 20-30 minutes.

3.5. Data Analysis

Once data analysis had begun, increased efforts were made to bracket and bridle the natural human tendency to prematurely apply meaning and draw conclusions. "Bracketing" can be described as "the restraining of one's pre-understanding in the form of personal beliefs, theories, and other assumptions that otherwise would mislead the understanding of meaning and thus limit the researching openness" of a study (Dahlberg, 2006, p. 16). "Bridling" extends to the overall method of interpretation and understanding, whereby the author believes that full understanding of the phenomenon of study may never be attained and therefore adopts a stance of reflection and indefinite conclusion (Dahlberg, 2006).

The analysis was an inductive process – data was gathered to "build concepts, hypothesis, or theories, rather than deductively testing hypothesis" (Merriam & Tisdell, 2016, p. 17). Phases of data analysis were conducted following Creswell and Poth's (2018) "Data Analysis Spiral". As is common in qualitative research, data collection and data analysis were not clearly demarcated by time and often occurred simultaneously (Creswell & Poth, 2018). This was especially true of the first two activities of the data

analysis spiral, “Managing and organizing the data” and “Reading and memoing emergent ideas.”

After each workshop in which data collection occurred, new graduate nurse surveys were collected, scanned, and reviewed by the author to gain a cursory understanding of participant responses. Surveys were collected over a period of four workshops, whereas focus groups were held over a period of three workshops. The difference was by design – the first set of data collected and analyzed were surveys. This allowed the author to review responses and determine whether the original questions provided in the interview guide were on track or required edits. This first set of data were unsurprising and so the interview guide was left in its original format.

Over the next three workshops, data collection expanded to include both new graduate nurse focus groups and surveys. As there were now two types of data to review and analyze, it allowed for the construction of an initial framework of what themes may have been emerging with regards to the research questions. After each focus group interview was completed, reflection upon the interaction was done and notes were made by the author in order to capture any patterns or meaning of these thoughts over time. Focus group interviews were transcribed within a month of the interview.

A total of 44 new graduate nurse survey participants and 16 focus group participants were enlisted. Respondents were employed in various subspecialties such as home health, mental health and substance use, medicine, surgery, and other. There were a mix of genders, ages, and ethnicities. These characteristics were not formally accounted for and will therefore not be discussed in the “Findings” or “Discussion” chapters.

Clinical educator surveys were gathered over a period of two weeks. Following this, interviews were completed over the course of one month. As with the process for new graduate nurse data, clinical educator surveys were scanned and read prior to interviews to gain a preliminary understanding of participant thoughts and ideas related to the study. This was done to provide interviews with direction beyond the questions in the semi-structured interview guide. For instance, it was not foreseen that healthcare educators would have such a wide variation in how much they valued patient family partner contributions. In reading the survey responses, it became clear this was the

case. That knowledge helped inform the interviews as the author was prepared to ask specific questions about challenges as they were reflected in the survey responses if they did not come up naturally in the interview process. Interviews were transcribed the following month by the author.

Six clinical educators chose to participate in the study. All completed the surveys in June of 2019. A mix of focus group and one-on-one interviews with all six clinical educators were conducted throughout the month of July.

Two patient family partners chose to participate in the study. Both were interviewed by the patient research partner one-on-one. Only one survey was collected – due to this exceedingly small sample size, its contents were not included for this study.

New graduate nurse and clinical educator surveys and interviews were coded and classified one immediately after the other; the next step in the Data Analysis Spiral (Creswell & Poth, 2018). Likert-scale survey data were tabulated and interpreted using Microsoft Excel. Open-ended survey data and interview transcriptions were read through and coded using the NVivo (2018) qualitative data analysis software.

Continuing along the Data Analysis Spiral to “Developing and assessing interpretations of the data”, nine themes and 24 codes were initially developed. Aware of the fact that novice researchers have a tendency to develop more themes and codes than are necessary (Creswell & Poth, 2018), the author re-reviewed data from multiple angles with the guiding principle of how to develop themes in a way which authentically represents participants’ views. At first, ideas had been themed as they appeared to come forth through the data. Over time and through deeper reflection, it became apparent that much of what had first been seen as themes were in fact codes, as they were linked by a more specific commonality. Other initial themes were abandoned as although interesting, they did not pertain to the research questions. Ultimately, three themes and eight codes were decided upon. The codebook is available in Appendix F.

3.6. Limitations

There are a variety of limitations to this study. With regards to patient-oriented research, the first limitation is that although there are calls nationally and internationally for its use, it has not been proven to create better or more effective findings or research

agendas (Manafo et al., 2018; Moran & Davidson, 2011). Furthermore, despite following recommendations for patient engagement in research throughout this study's progression, unforeseen challenges resulted in a change of patient research partners at the point of data collection until the completion of research. This may have impacted continuity in the research as well as participant recruitment. With regards to continuity: the first patient research partner consulted on the research problem and research design and collaborated with the author on the research question. The research process was new for this patient research partner; the second patient research partner is what is known in some circles as a "super patient": "individuals who contribute frequently to research engagement opportunities, thus enabling their voices to be included multiple times," with concerns from the patient-oriented research community that super patients' exposure to research and their formal training and experience results in "the potential loss of their ability to represent a lay person's point of view" (Black et al., 2018, p. 164). As this second patient research partner joined the team late in the research process, there was no time to re-consider all aspects of the study and therefore two different perspectives colour different portions of the study.

Concerning participant recruitment: only two out of an eligible eight patient family partners participated in the study. This may be due to timing and change in personnel: patient family partners were originally contacted in the Spring and given four months of time to participate in the study. However, as a result of commitment and communication challenges between study personnel this original data collection period was changed: the second period of recruitment for patient family partners occurred for two months over the Winter, including the holiday period.

Also with regards to patient family partner recruitment: the study's inclusion criteria had specifically called for participants within the Metro Vancouver area – this had been done in the hopes that face-to-face interviews could occur. It quickly became apparent however that it would be much more convenient for patient family partners as well as the patient research partner conducting interviews to hold these interviews over the phone. While the interviews may have flowed more naturally and fluidly in person, the added difficulties of performing interviews in person would likely have decreased the already small number of patient family partners who were willing to participate. While this particular recruitment criterium (of living within the Metro Vancouver area) did not have an impact on recruitment numbers as there were no patient family partners living outside

of this area, it remains something the author would have done differently if given the opportunity.

With regards to data collection, resource limitations including time, funding, and personnel resulted in sub-optimal numbers of patient family partner participants and overall small sample sizes. Data collection was a mix of surveys, focus groups, and one-on-one interviews done either in-person or over the phone. Had resources been available, the author would have liked to have all interviews conducted face-to-face and one-on-one to capture body language and to have the ability to ask additional or clarifying questions in real time. While focus groups allowed for participants to construct a social and shared understanding of the questions and comments provided, one-on-one interviews may have allowed for more nuanced responses and further exploration of each individual's point of view, including the indifference towards the inclusion of real patients in simulation mentioned by several participants (see Section 4.2.2). As it stands, there was no mention made of this indifference during focus group interviews, though it did appear in the survey data.

The language in the surveys geared towards new graduate nurses (see Appendix A) may have contributed to the confusion between real patients/patient family partners and simulated patients/actors (see Section 4.1.3). Instead of switching between the terms "real patients" in the Likert scale statements and "patient family partners" in the open-ended questions, the term "real patients" should have been used throughout the survey. A short paragraph explaining the difference between the terms at the beginning of the survey may also have helped clarify the two populations.

The space in the surveys which allowed participants to draw an artistic representation of their experience ended up not making its way into the findings. While there were a few images which were similar, the author realized that she was ill-equipped to approach thematic analysis of images. Future attempts to incorporate non-traditional survey methods should be overseen by researchers with the means to explore those media.

Chapter 4. Findings

Three main themes were developed from the data: Findings specific to simulation and co-debriefing, Beliefs surrounding patient- and family-centred care and the inclusion of patient family partners, and Relationships.

4.1. Findings specific to simulation and co-debriefing

Adding patient family partners into simulation-based education appears to have impacts specific to the complex nature of this education modality. Due to its performative nature simulation-based education can threaten learner engagement in a variety of ways, especially if learners “feel exposed by the simulation and debriefing in a way that threatens their personal identity,” and/or “they feel defensive discussing performance that falls short of a standard” (Rudolph, Raemer, & Simon, 2014, p. 339). As such, conducting the debrief is a difficult skill to master (Eppich & Cheng, 2015; Grant, Robinson, Catena, Eppich, & Cheng, 2018), and maintaining psychological safety is of utmost importance (Eppich & Cheng, 2015; Kolbe et al., 2019; Kolbe, Grande, & Spahn, 2015; Rudolph, Simon, Dufresne, & Raemer, 2006). Co-debriefing adds another layer of complexity and has both benefits and challenges (Cheng et al., 2015).

Simulation-based education may also employ the use of standardized or simulated patients. Defined in the Healthcare Simulation Dictionary as “A person who has been carefully coached to simulate an actual patient so accurately that the simulation cannot be detected by a skilled clinician” (Lorprieto et al., 2016, p.32), simulated patients have been part of medical education since the early 1960’s (Barrows, 1968).

The data gathered through this study reveal that the above-mentioned facets of simulation-based education were all impacted by the inclusion of patient family partners as co-debriefers. The three sub-themes found are: Anxiety related to performance and maintaining trust in healthcare professionals; Challenges of co-debriefing; and Confusion or overlap between “patients”.

4.1.1. Anxiety related to performance, and maintaining trust in healthcare professionals

Anxiety was a theme which emerged early on, as it was evident in nearly all aspects of data collection. For the purposes of this study, mentions of anxiety, stress, intimidation, increased difficulty, fear, worry, increased pressure, nervousness, and/or expressions of being in a position of high vulnerability were all classified as "anxiety". In most instances, the presence of patient family partners during the simulation-based education activity increased anxiety, as evidenced by the following new graduate nurse responses to the survey question, "What did/do you find challenging (if anything) about having patient family partners as a part of the simulation experience?"

> I think it made it more stressful but more realistic (Participant 15)
>
> A little intimidating, but overall good :) (Participant 33)
>
> Challenging. Scared of doing something wrong, not to their [patient family partner's] expectations (Participant 47)
>
> Felt more pressure not to mess up (Participant 50)
>
> Increased self-consciousness + fear of mistakes (Participant 53)

However, as alluded to by participants 15 and 33, this increase in anxiety was not necessarily seen as negative. Focus group interviews with new graduate nurses confirmed this, as explained by the below quotes:

> Interviewer: Any downsides or challenges that you think are applicable when there's a real patient observing [the simulation]?
>
> Participant 1: I think that it's a little bit more intimidating but I think that it's also like, way more realistic. Because I think it's a little intimidating in real life when you have someone watching you [others nodding] in a situation, whether it's a crisis or not. And so I think it made the scenario feel much more real because you had that sort of, like, performance anxiety sort of [others laughing and nodding] because, like yeah, I feel like that made it real for me. (new graduate nurse Focus Group 1)

Further along in the above conversation, the theme of anxiety was clarified:

Interviewer: And you guys had mentioned anxiety a few times, so it seems – and I don't want to get it wrong – it seems to me like that anxiety is good in the sense that it's like, this is what would happen in real life?

Participant 1: Mmhmm

Interviewer: Would that be like a correct assumption of what I'm saying?

Participant 2: Yes

Other participants: Yes [nodding]

Participant 2: We need to practice that – the more the better

Participant 1: Yeah, I mean, I would be much more anxious in real life than in that [simulation] room so, I think it's good (new graduate nurse Focus Group 2)

These quotes point to an increase in realism – or what the simulation community terms "fidelity" or "functional task alignment" (Hamstra, Brydges, Hatala, Zendejas, & Cook, 2014) – between the scenario objectives and the inclusion of patient family partners. This concept will be further explored in the "Discussion" chapter (Section 5.1.1).

Another contributor to the increase in anxiety felt by participants relates to how patient family partners might react to the performance of new graduate nurses during the simulation, and its possible effect on the overall trust patient family partners have in the healthcare system. The following two survey responses reflect this:

> You want to do a good job because they [the patient family partners] are there, and you want to make them feel like they can trust us (Participant 2)

> Nervous to make some faux-pas they [patient family partners] have experienced with other HCPs (Participant 55)

Indeed, this is a valid cause for concern. As explained by one of the patient family partner participants below, what patient family partners see during the simulations can have real-life impacts on their perception of healthcare providers. However, as patient family partners have all had much experience in the healthcare system and are aware of the challenges new graduate nurses face, patient family partners can be quite sympathetic:

> And we [the two actors and I were] like, our eyes were like deer in the headlights, we couldn't believe what we had just witnessed of this unfortunate new grad who, who just didn't know what to do, and it kind of left me wondering like, what's the follow up? … it's concerning, right? And it wasn't actually, it didn't happen only one time; there was a couple other occasions. … so those two or three who like, that have come through that, you know, just it's quite shocking that this person is actually a nurse at this point, it's kinda scary… but that's why I think these new grad workshops are so valuable, because new grads, they need the support. …patients and families just want to know that the nurse will do the best they can, and if they don't know something, they're going to make sure they get the appropriate help. I think that's the bottom line and safety and all that. And to make sure that their patients and families are cared for and listened to, right? (patient family partner interview, Participant X)

Although the presence of patient family partners increased anxiety during the simulation scenario for many participants, I found no evidence of negative consequences. Even so, the impact of questionable performance in a simulation and its effect on the trust between patient family partners and healthcare practitioners is a question which merits further exploration. Though it did not appear to have a definitive negative impact in my findings, its overall effect remains uncertain due to both the small sample size and short duration of the study.

4.1.2. Challenges of co-debriefing

Maintaining psychological safety during simulation is a key tenet when it comes to simulation-based education. Described as an environment in which team members feel safe to take interpersonal risks (Edmondson & Lei, 2014; Rudolph et al., 2014), psychological safety can be particularly challenging to attain during the debrief post-simulation (Kolbe et al., 2019). The reasons for this are multi-faceted, but in large part can be attributed to a combination of the performative nature of simulation-based education, whereby individuals' performance is "on display" for all to see; the simulation scenarios themselves, which are often challenging for participants by design; and organizational culture, which still has remnants of the old view that making mistakes is an errant behavior to be punished, rather than a common occurrence from which we can all learn (Kolbe et al., 2019).

Co-debriefing, too, has its challenges. Cheng et al. (2015) define co-debriefing as "more than 1 facilitator conducting a debriefing session, when these facilitators may be

from the same or different professional backgrounds or specialties" (p.69). Though there are many benefits to co-debriefing, such as facilitators having a larger pool of expertise and experience to draw from, challenges also exist, such as misalignment between facilitators when it comes to the simulation's learning objectives (Cheng et al., 2015).

Our findings indicate that these existing benefits and challenges within simulation-based education were reflected in the co-debriefing experience of many clinical educators, but less so in the experience of the patient family partners and new graduate nurses. In this section, challenges are described. Benefits are highlighted in the section, "Beliefs surrounding patient- and family-centered care and the inclusion of patient family partners".

As with the new graduate nurses, feelings of anxiety and discomfort were also described by clinical educators during simulation-based education. The underlying cause of these feelings was due to uncertainty regarding what and how patient family partners might contribute to the debrief discussion:

> You build up the whole day saying "it's safe it's safe it's safe," and we're trained to give feedback and debrief in a non-accusatory way that's meant to help you apply situations in the future and lessons learned, but the way they're [the patient family partners are] phrasing it, yeah, to me appears quite judgmental. And so, then we're contradicting the whole safe nature of sim[ulation]. (Participant 3a, Clinical educator interview 1)

> I would say that the challenge is that it's [the session is] unpredictable. And that remains consistent. Because it tends to be variable patient family partners, and that's okay, but if they're new to it or haven't done it before my concern is that I never know what's going to come out of their mouths so … unfortunately it tends not to be what I envision their role to be. (Participant 6a, Clinical educator interview 1)

> The harsh part, at the beginning for me was just, for me, they were critical versus giving constructive feedback. It was quite critical and in assuming that you know, like quite accusatory I think, at the beginning. But then it got better. (Participant 1a, Clinical educator interview 1)

> …there is a little bit of concern in that they do bring in their personal experiences. Maybe too much? In that it turns into a counseling session rather than more of a debrief of the scenario…it's not in alignment with what the actual intentions are of the actual sim[ulation]. (Participant 4a, Clinical educator interview 2)

The specific concerns in the above quotes relate to the maintenance of psychological safety for the learners, the misalignment of learning objectives between facilitators, and possibly differing personal agendas between facilitators – all of which have been previously described as challenges to co-debriefing in Cheng et al.'s (2015) seminal paper on the topic. The quotes from participants 1a and 6a above indicate that what may be contributing to these concerns is the infrequency of co-debriefing between facilitators accompanied by an unfamiliarity between each other.

Indeed, it appears as though once co-debriefers are able to establish rapport with one another and have the opportunity to become familiar with each other's agendas, they experience less uncertainty and feel more at ease:

> I find that when I've worked with the same patient family partners repetitively, because it's often the same ones who'll come to [this site], that that actually helps immensely. … You know, if you've been really clear with the expectations and created a bit of a relationship with whoever the patient family partner is for that day, 'cause then I think then they have a better idea of what they can contribute in the debriefing. And I think it is a very difficult skill…and I think it comes more naturally to some people than to others and so, I think sometimes they do - they can get kind of off topic or on tangent. And at the same time you can re-direct them as a facilitator to notice certain things… instead of them maybe acting as the debriefer I'll ask them directly the question as a patient family partner and then they kind of have the opportunity to say something or to engage the other participants. (Participant 2a, Clinical educator interview 1)

> We want to keep them [the patient family partners] – you kind of learn and accumulate experience and you do better this way, I find. … If you are not consistent, you cannot [make the] commitment and you can't do it all the time - I kind of find it hard to work with those people. …some I work with them quite comfortably, I see them quite - almost every month when I was doing it more often. Then I, we know how to work with them. They know me, I know them, we worked together before, we know how to bounce back and forth and that's our style. Whereas from a new person, you have to learn, and you have to form that relationship. And then if every time I have to spend some time with [them], to form a relationship and then don't know whether this [communication style] is the best way to go – it's harder. So to me, it would be good to work with a set of people consistently. I think that will make the learning a bit better and then the workshop, the debriefing part a bit smoother. (Participant 5a, Clinical educator interview 3)

> I do think consistency is consistently a problem. …I think that there's a certain familiarity that comes with having been a patient family partner through several different iterations of [the workshop] and seeing how different learners are…and they [patient family partners] need as much

> practice as we do, and I don't know that they're getting that. They get some training but I think it would be marvelous to have similar patient family partners. …it's on two hands now the number of different patient family partners who have come through – and it's anybody's guess what they're going to say… (Participant 6a, Clinical educator interview 1)

New graduate nurses did not make mention of any appearance of miscommunication or misalignment between patient family partners and clinical educators. Of the two patient family partners who participated in the study, there was one mention related to the challenges of debriefing:

> For me it was kind of limiting, because I'm a trained facilitator and I've done a fair amount [of communication]. I think that our life experiences, it would be nice if the educators understood that we've all ... had experiences, life experiences and maybe rather than trying to orchestrate specific means of communication between us, which I found limiting for the first oh, probably two or three scenarios that I, times that I went, to just let things flow a little more naturally. (Participant Y, patient family partner interview 1)

This comment seems to reflect another challenge of co-debriefing previously described by Cheng et al. (2015): unfamiliarity between co-debriefers, leading specifically to co-facilitators not knowing or appreciating the strengths and potential contributions of one another. These co-debriefing challenges will be further explored in the "Discussion" section of this paper.

4.1.3. Confusion and/or overlap in roles between "patients"

During the study, it was immediately apparent that many new graduate nurses were confused as to who the "real" patients, or patient family partners, were in the simulation activity. When filling out surveys, new graduate nurses often asked whether a real patient had been present during the simulation - when they were reminded that there had been a patient family partner involved in the simulation, new graduate nurses appeared to have forgotten that the patient family partner had been an actual patient in the past. At the start of each new graduate nurse interview, there was a need to re-define and delineate who during the activity had been the patient family partner. Similarly, while completing the survey several small groups of new graduate nurses asked what the difference was between the actor and a real patient. This was again reinforced by some of the answers to the survey questions, "What did/do you appreciate (if anything) about having patient family partners as part of the simulation experience?"

and “What did/do you find challenging (if anything) about having patient family partners as a part of the simulation experience?”, which clearly indicate confusion between the patient family partner and simulated patient roles. Note that patient family partners do not take active part in the simulation scenarios, and do not provide information about the scenario itself, but rather act solely as observers during this time.

> They can add elements to the scenario that are unexpected which adds extra challenges & makes you think on the spot (Participant 13)
>
> Having actors was great, made sim seem more real (Participant 23)
>
> In the anaphylactic situation, the family member amped up the stress level, which could very well represent real life scenario (Participant 25)
>
> I was able to obtain more information about the patient. Their medical condition, history and baseline in order to treat them more effectively (Participant 42)

These responses make it clear that several participants confused the simulated patients in the scenario with the patient family partners.

There was also overlap between the two types of “patient” roles in terms of providing feedback to learners. This was expressed by interviewed participants of each role. Here, a patient family partner speaks to how the feedback from the simulated patients often mirrors their own:

> I really am trying hard to put myself in the position of the patient, yet if the [simulated] patient also has feedback to give the new hires, so that person, as an actor though, that's a great perspective too, because I've noticed that they really do have great feedback for the new grads. Those actors’ feedback are really great. And they really do parallel very much with how my comments were often, how I would feel as the patient or the family member. (Participant X, patient family partner interview 2)

Similarly, the clinical educator below has highlighted the overlapping roles of the simulated patients and real patients, indicating that the simulated patients alone may be enough to meet the objectives of the session, which are to promote and consider patent- and family-centred care:

> …we also have two standardized actors [simulated patients], we have a family person [patient family partner] in and we have a patient and a caregiver [the roles of the simulated patients] and that helps when we do the debrief to be able to not just talk about what the actions were with the patient in question, but how did we draw in the family member?

> So I think there are opportunities to do that in the debrief, personally, without having the patient family partner necessarily be there. I also want to add that I have done sessions where there hasn't been a patient family partner and we've still been able to talk about patient- and family-centred care. (Participant 6a, clinical educator interview 1)

Likewise, this new graduate nurse preferred the feedback from the simulated patients to that of the real patient:

> Survey question: What did/do you find challenging (if anything) about having patient family partners as a part of the simulation experience?
>
> Participant 26: An extra person in the room. I felt the feedback from the actor [was] more helpful.

From these comments, it appears as though role confusion and overlap between simulated patients and patient family partners was experienced by both the new graduate nurses and clinical educators.

4.2. Beliefs surrounding patient- and family-centred care and the inclusion of patient family partners

There was a wide range of beliefs among participants surrounding the inclusion of patient family partners in the simulation scenarios. Often, this hinted at what participants' understanding and beliefs were surrounding patient- and family-centred care.

Survey data indicate that the vast majority of new graduate nurses agreed that the inclusion of real patients was beneficial. This is reflected in the results of a few different Likert questions related to real patients.

Table 4-1. New Graduate Nurse survey data related to real patients

Survey Question	Range	Mean	Median	Mode
The presence of real patients stimulates my learning of the simulated clinical situation*	3-5	4.84	5	5
I believe that the knowledge the real patients convey is valid for my learning*	3-5	4.77	5	5
The presence of real patients generate feelings of empathy and compassion for me*	3-5	4.8	5	5
I have a better understanding of the care provided if I reflect with a real patient in the debriefing*	3-5	4.68	5	5
I think the debriefing with real patients helps me consider the patient and family in their my daily practice*	3-5	4.8	5	5
I would recommend including real patients in clinical simulation scenarios*	1-5	4.66	5	5

*question has been replicated from Díaz-Agea et al.'s (2017) study

Survey data from the clinical educators is much more mixed. There does not appear to be consensus regarding any one question, and some of the questions clearly divided the respondents. Note especially that for the last two questions, the "strongly disagree" and "strongly agree" responses occurred with equal frequency.

Table 4-2. Clinical Educator survey data related to real patients

Survey Question	Range	Mean	Median	Mode
The presence of real patients stimulates learning of the simulated clinical situation for new grad nurses*	2-5	3.5	3.5	2, 5
I believe that the knowledge the real patients convey is valid for learning for new grad nurses*	2-5	3.6	4	4, 5
The presence of real patients generate feelings of empathy and compassion for new grad nurses*	1-5	3.5	4	5
New grad nurses have a better understanding of the care provided if they reflect with a real patient in the debriefing*	1-5	3.7	4.5	5
The debriefing with real patients helps new grad nurses consider the patient and family in their daily practice*	2-5	4	4.5	5
I would recommend including real patients in clinical simulation scenarios*	1-5	3.2	3.5	1, 5
I think the benefits of including real patients are not worth the risks	1-5	3	3	1, 5

*question has been replicated from Díaz-Agea et al.'s (2017) study

As there was a variety of viewpoints, the theme of "Beliefs surrounding patient- and family-centred care and the inclusion of patient family partners" has been subdivided into two sub-themes: Benefits of the inclusion of patient family partners, and indifference related to the inclusion of patient family partners.

4.2.1. Benefits of the inclusion of patient family partners

Thirty-three of the 44 new graduate nurse survey respondents made mention of the benefit they experienced from the inclusion of patient family partners. In focus group interviews, new graduate nurses expressed that they valued the inclusion of patient family partners primarily for the perspective and experience they brought to the session. Their comments also reveal the differing underlying beliefs and approaches to patient- and family-centred care they may hold. For example, Participant 52 appears to believe that patients are the experts of the healthcare system experience and we should therefore be improving our system according to their feedback:

> I just think it's so important for us to learn from people with lived experience. I think we spend our whole time in nursing school learning about theory and from a textbook and this research says this and not a lot of research necessarily includes patient voices. And I think that that's just a huge, important thing to learn from – is people with actual lived experience. Because I think that's how we can make our healthcare system better – like, they know the healthcare system the best. (Participant 52, new graduate nurse Focus Group 3)

Participant 25 on the other hand, seems to approach patients and families as equal partners with everyone else involved in the healthcare experience:

> …including the patient is like, another interdisciplinary in a sense, they're just another voice, 'cause we all need to know what everyone else is thinking and we have to empathize in each different situation – okay, what are the pressures the doctors are facing, or what are the pressures the patients are feeling and that way I think we can work on our communication skills and empathize. What does this person need to know, what is helpful for them to feel comfortable, and that we're doing the right thing - just sort of keep the communication open the for everybody. (Participant 25, new graduate nurse Focus Group 1)

Whereas Participant 19's comment highlights the individualized aspects of patient and family care.

> I think it's helpful to have like, a real person who's been through it there to give their feedback. I mean every situation's gonna be different anyways but someone who's actually been through it can provide more understanding and insight. (Participant 19, new graduate nurse Focus Group 1)

We will return to the concept of differing views and levels of patient engagement in Section 5.1.2. of the "Discussion" chapter.

Many new graduate nurses also made comment on the usefulness of the specific feedback the patient family partners gave, as it revealed behaviours or concepts the new graduate nurses were either not aware of or had forgotten.

> I think one of the main things I got reminded of is when, if a physician or a nurse says a bunch of stuff and the patient kinda nods, it doesn't always mean that they understand. …she [the patient family partner] would go there [to the doctor's appointment] and the husband's like, "uh huh, uh hmm," and then she'd be like, "honey, you don't actually like…do you understand what's going on?" and he didn't really. Like he thought that he was going to be cured. (Participant 25, new graduate nurse Focus Group 1)

> It was really good to have someone actually say, "You used this kind of language and it affected me this way." 'Cause like, I just said something super off hand, "Oh their vital signs are out of whack," or something. And the way they [the patient family partner] interpreted that, was like, "What does that mean, is everything okay? I don't know what that is." And so, to say something in the moment when you're just trying to get interventions [done] as quickly as possible and not realize, "Oh, yeah, that can be alarming to someone, they might not have any idea what that means." It was good getting that perspective. (Participant 1, new graduate nurse Focus Group 2)

Survey question:	What did/do you appreciate (if anything) about having patient family partners as a part of the simulation experience?
Participant 21:	It made the scenario more realistic and reminded me to vocalize what I am doing to not only the pt [patient] but family member too.
Participant 45:	They offered their perspectives on the care, which was useful to know what we did well and should continue doing, and what we should do differently. Learning about the health care experience for them, what it's like.
Participant 53:	Being reminded that there is a human being to care for before worrying about disease or diagnosis

Patient family partners also find benefit in being a part of the education session. The comments below seem to indicate that there are a variety of ways in which participating in co-debriefing can serve patient family partners, such as by providing them with a sense of positive value, a sense of contribution to the development of new graduate nurses, a feeling of accomplishment in promoting patient- and family-centred care, of

feeling heard, and having the impression that by improving the skills of new graduate nurses, they are impacting the community at large:

> It's been a positive experience for me because I feel that the participants - new grads - value the comments I make. … And I feel that I know that because, just some of the comments we've had, and some of the things they say. …I feel like I'm participating in being a part of something that is of benefit to them as a whole. … I have heard some of the new hires say at the very end of it [the simulation], that they have a renewed appreciation when nursing, to make sure it's patient- and family-centered and that's really cool for me to hear… (Participant X, patient family partner interview)

> [I] have always had an interest in health and health care… and I want it done in the way I wanted it done. So if I don't participate, nobody's going to speak up for me, right? So, personal interest as well as hoping to shape the medical field in my own little neck of the woods as best I can. … I know how important communication is, and I know how important it is for me to get clear information from my doctor or my healthcare professionals. So, when this opportunity came up to be part of training for new nurses, I felt I had some skills and I felt I had a vested interest in how people are treated in a hospital and in the outer community. (Participant Y, patient family partner interview)

Though feedback from clinical educators regarding the inclusion of patient family partners as co-debriefers was mixed, half of the clinical educator participants found benefit to this intervention. Perceived positive contributions made by the partnership with patient family partners relate to role-modeling and living the values of patient- and family-centred care, the provision of feedback for the new graduate nurses from an authentic and lived experience point of view, and learning on the part of the clinical educators themselves:

> I think having them [patient family partners] present really makes it obvious to us as facilitators and debriefers as well as the participants in the room just how important and valuable it is so people pick up on those patient- and family-centred care principles kind of cues maybe more so than they would in other situations. (Participant 2a, Clinical educator interview 1)

> They [the patient family partners] offered a unique perspective and observations to the care of the patient, that may have otherwise been [missed] by those who have not been patients. The feedback from the New Grads is often that they learned from the patient family partners the most. (Participant 1a, survey response)

> It has been a very positive experience for me to work with them [the patient family partners] because I not only think that they contribute greatly to the learning in new graduate nurses, I also learn from them,

> from their perspective, from a patient's lens: How can we do better? How can we make this thing better? Or how can we make the care, the quality better. So I learn a lot from them. (Participant 5a, Clinical educator interview 3)

The other half of the clinical educator participants, who did not agree that there was clear benefit from the inclusion of patient family partners in the workshop, still appeared to value the concept of patient- and family-centred care and the patient and family lens, but thought the engagement would do better in a different format. It was the unpredictability in simulation, and/or how the simulations were scripted, which led them towards a more neutral outlook regarding the value add of the patient family partners in their experience:

> …it's not that I don't see the potential, I just don't know if sim debriefing is the right venue for it [the inclusion of patient family partners]. So, do we have them talk before [the] simulation, like twenty minutes before and they talk about their story and what happened to them and they leave and then we go ahead and do a safe sim space… I don't know if what they're capable of adding is best suited in the sim debrief portion. (Participant 3a, clinical educator focus group)

> Participant 4a: I think there's potential… I think if they [the patient family partners and workshop developers] just hone in a little bit more on how those [patient family partner] experiences can be converted to a learning environment, it could be very helpful. I mean the emotional aspect as well… How do you deal with the emotion? …the sister can start balling because you know, look at what she's experiencing right in front of her eyes. The wife could break down in tears because her husband's getting forgetful… And so how do you deal with that.
>
> Interviewer: What I hear you saying is the emotional aspect would be [increased] in the simulation and then the patient family partners could speak to the emotional aspect and their experience of it.
>
> Participant 4a: Yeah, mmhmm. And maybe they'll [the patient family partners] get more out of it too and feel a bit more validated (clinical educator interview)

4.2.2. Indifference related to the inclusion of patient family partners

While the majority of new graduate nurses found benefit in the inclusion of patient family partners as co-debriefers, it was not a unanimous finding. Survey responses from new graduate nurses indicate that there was neutrality/indifference

related to some of the proposed benefits of the presence of real patients in the education session, with one new graduate nurse strongly disagreeing that they would recommend including real patients in clinical simulation.

Table 4-3. Number of New Graduate Nurse survey respondents who did not find benefit in the addition of real patients in co-debriefing

Survey Question (indicate the score you consider most consistent with the opinion you have about the following statement)	**# of respondents out of 44 who indicated**		
	3 - Neutral	**2 – Disagree**	**1 – Strongly Disagree**
The presence of real patients stimulates my learning of the simulated clinical situation*	1	0	0
I believe that the knowledge the real patients convey is valid for my learning*	3	0	0
The presence of real patients generated feelings of empathy and compassion for me*	2	0	0
I have a better understanding of the care provided if I reflect with a real patient in the debriefing*	4	0	0
I think the debriefing with real patients helps me consider the patient and family in my daily practice*	3	0	0
I would recommend including real patients in clinical simulation scenarios*	4	0	1

*question has been replicated from Díaz-Agea et al.'s (2017) study

This indifference was not captured in the focus group interviews. Neither was it well-captured in the open-ended survey questions, though a few new graduate nurses who scored one or more of the real patient-related statements as three or less did provide some feedback:

> Survey question: What did/do you find challenging (if anything) about having patient family partners as a part of the simulation experience?
>
> Participant 36: An extra person in the room. I felt the feedback from the actor is more helpful.
>
> Participant 26: They sometimes seem to make the sim feedback portion less comfortable.
>
> Participant 11: Pt. [Patient] can have very subjective experience that they are focus[ed] on which may be limiting the learning experience

It is difficult to draw any conclusions from these responses. We can see though, that the responses provided by Participants 26 and 36 relate specifically to simulation as an educational method: Participant 26's response is specific to debriefing and possibly, the

performative nature of simulation. Participant 36's statement, as we've seen before, relates to the overlap in roles between real patients and simulated patients. Note that simulated patients however, are only ever employed within simulation-based activities. On the other hand, Participant 11's response is a much more general statement about the inclusion of patient-teachers and reflects some of the unanswered questions about patient and family engagement at large.

There were also clinical educators who shared a neutral opinion about the inclusion of patient family partners in simulation. Two of the six clinical educators expressed that while they personally found the experience anxiety-provoking due to the uncertainty of what patient family partners would say, their overall impression of the inclusion of patient family partners in the simulation sessions was neutral:

> I think that my last few sessions, it's [the inclusion of patient family partners has] not been horrible but it's also – I don't think it's added. (Participant 6a, clinical educator focus group)

> I don't see the positive but at the same time you know, it's not super damaging, them [the patient family partners] being there because even though they don't phrase things correctly, no one ever leaves in tears, right? They're good people, volunteers, so I understand why they're there. …but at the same time they're not negative, so for me it's neutral. (Participant 3a, clinical educator focus group)

Similarly, when asked about the contribution of patient family partners to the simulation scenarios, another clinical educator highlighted that the learners – in this case, the new graduate nurses – wouldn't necessarily appreciate the difference between having patient family partners present or absent in the learning session:

> It's [the format of the simulation session with simulated patients, patient family partners, and clinical educators] all new to them, so anything we say or do is quite new to them. … So they don't really know the difference. (Participant 4a, clinical educator interview)

As a group, patients were evenly divided between those who found benefit in working with patients as co-debriefers in simulation, and those who were neutral or indifferent about what they added.

4.3. Relationships

The final theme interpreted through the data is about relationships – the perceived relationship between the clinical educators and patient family partners, which is encompassed by respect; and the sense of maternalism on the part of clinical educators towards the new graduate nurses.

4.3.1. Respect

Due to the history of paternalism in medicine (De, 2004; Mccullough, 2011) and the novelty of including patient and family representatives in the continuing professional development of healthcare professionals (Cox et al., 2016; Jha et al., 2009b; Towle & Godolphin, 2013), one of the motivating questions of this study "How do members from each role perceive the relationship between roles?" focuses specifically on the relationship between clinical educators and patient family partners. All study participants were asked about this relationship.

Nineteen of the twenty-six new graduate nurses who responded to the survey question below made definitely positive comments. Examples include:

Survey question:	Do you have any comments about the relationship between patient family partners and healthcare educators, as you experienced it?
Participant 13:	It's great to see the collaboration between the 2, it shows that healthcare educators are bringing the family partner's voice/thoughts/opinions to the learning process
Participant 5:	Everyone was professional, respectful and sensitive to each other's participation
Participant 29:	It seems that they both value their contributions and highlight the importance of their role/perspectives

Five of the clinical educators also had positive comments to make about the relationship between themselves and the patient family partners, regardless of whether or not they had experienced uncertainty or misaligned personal agendas with regards to the experience of co-debriefing:

> I think the relationship is quite good. I haven't had any issues. We have great conversations - you know they're excited to be there [and] we're excited to have them there. (Participant 4a, clinical educator interview)

> …most of them are absolutely lovely and are not there with any intent to do anything other than help… it's always with excellent intentions that they arrive. I think, again, they're volunteering for a reason, so I really value that they are wanting to give their time and be a part of this. (Participant 6a, clinical educator focus group)

One of the clinical educators did comment on a possible hierarchy between the two roles, but quickly made it clear that this was not the intent:

> I think there's a hierarchy there. Like, to me, they see – now I don't know, I'm making stories – some may think that you are the healthcare provider, you are higher, you know more, you know better. But [do] I? I'm also learning. Like, I'm learning together. Right? So that is just an assumption that we've made about each other, which, it happens a lot. And so, once we have eliminate[d] that … the way I do things with the patient family partners and I think, we have to be equals. Like, we're partners – patient family *partners*, right? (Participant 5a, clinical educator interview)

Despite participant 5a's concern about a perceived hierarchy, none of the new graduate nurses, and neither of the patient family partner participants made any mention of a power imbalance between the roles. When patient family partners were asked about the relationship between them and the clinical educators, only positive comments were made:

> I mean, they [clinical educators] were always very, very polite and very grateful. Always expressed their thanks and thanked us at the end as well, and recognized us. (Participant Y, patient family partner interview)

> All the educators, they've been just awesome, all of them, and you know, honestly I can't say enough good about them; they're just so thoughtful and respectful and make me feel valued and you know, included and yeah, really great. (Participant X, patient family partner interview)

The comments made by each of the participant groups overwhelmingly point to a sense of respect between the patient family partners and clinical educators, and a respect for one another's intentions related to the workshop.

4.3.2. Maternalism and clinical educators

"Maternalism" is described as "deciding to act in an autonomous person's best interests and likely in line with that person's will, but in the absence of the affected individual's expression of consent or assent" (Sullivan, 2016, p. 442). It is a relatively new concept in medicine (Sullivan & Niker, 2018). Maternalism is founded on the belief that in a trusting, understanding, long-time, personal relationship between a healthcare professional and a patient, the healthcare professional may reasonably make an informed decision about what their client would want in a given situation. However, as the decision is rooted in assumption, it can still turn out to be wrong (Sullivan, 2016).

In examining the data, the relevance of maternalism not only to the clinical educator and patient family partner relationship, but also to the clinical educator and new graduate nurse relationship was seen. Although the clinical educators did not have a longstanding relationship with each individual new graduate nurse who attended the workshop, the clinical educators were aware of the new graduate nurse experience at large (having been new graduate nurses themselves at some point), and as part of their role as clinical educators, required knowledge of literature specific to new graduate nurse practice and the new graduate nurse transition period. In light of these experiences, it can be argued that clinical educators are in a position to act maternalistically towards the new graduate nurses. Indeed, some participant remarks suggest this. Here we see Participant 1a's feelings of discomfort related to the perceived treatment of the new graduate nurses, despite not having heard new graduate nurses' opinions of how they felt patient family partners' feedback was delivered:

> At the beginning when I first started doing [the workshop] with them [the patient family partners] they were a bit more, it was a bit awkward and I felt like they were a bit harsh on the students when they were debriefing. (Participant 1a, Clinical educator focus group)

Although the below quote has been used previously, here Participant 6a's sentiment that the learners are their (Participant 6a's) responsibility is highlighted. Note that this sense of duty towards the new graduate nurses has not been asked of by the new graduate nurses themselves.

> The relationship [between clinical educators and patient family partners] is tricky in the room if the patient family partner is saying un-related and/or un-supportive things - the learners are *my responsibility*

> [emphasis added] and the patient family partners are volunteers where what they say is unscripted and therefore unpredictable. (Participant 6a, clinical educator focus group)

These comments allude to the ownership felt by the clinical educators to act in the new graduate nurses' best interest and maintain psychological safety, as previously described in section 4.1.2 of this document. Presumably, the new graduate nurses never explicitly stated that they wanted a psychologically safe space for debriefing, nor had they said that the patient family partners' feedback was harsh – indeed, as we've seen, new graduate nurses appreciate the comments made by patient family partners. Nevertheless, it appears as though the clinical educators had made these decisions and were worried *on behalf* of the new graduate nurses.

Similarly, another clinical educator made mention of the worry they felt for the patient family partners and their real and/or potential medical issues:

> She's excellent, but she's getting older and then, traveling down to the site to do it – it's getting harder and harder. And I'm always afraid that she'll fall. She's using a cane, and then I always worry that she's going to fall. And we're in an older building, right, so…I always make sure I walk her down if I can. …I want to make sure they're [the patient family partners are] safe. (Participant 5a, clinical educator interview)

Again, we can infer that the patient family partners themselves have not made mention of a fear of falling or requested an assurance of safety from the clinical educators. It is difficult to have any certainty in whether this clinical educator's concern was due to what they imagined the patient family partners would want, or if it was in their own self-interest; but the concern is real and may be a reflection of a maternalistic approach to the clinical educator-patient family partner relationship.

Chapter 5. Discussion

This chapter has two objectives: to discuss the previous chapter's findings and consider how they integrate with previously published research, and to attempt to marshal the evidence provided in the previous chapter to address the original research questions of this study.

5.1. Findings and the literature

Though many of the previous chapter's themes echo discoveries from previous research, the present study also generated some unique insights. These are discussed below under several themes and will add to the growing body of evidence related to patient-centred simulation.

5.1.1. Related to simulation-based education

Anxiety, fidelity, and learning

The increased level of anxiety felt by the majority of new graduate nurses due to the presence of the patient family partners in the simulation scenarios led to an increase in what is known in the simulation community as "phenomenal fidelity" (Dieckmann, Gaba, & Rall, 2007). Also known as emotional and experiential fidelity, phenomenal fidelity is the alignment between the simulation scenario and a real-life experience as it pertains to the overall, holistic interpretation of the situation. This includes such things as how the situation affects us emotionally, and how our beliefs impact our interpretation and experience of the situation. Phenomenal fidelity does not include the alignment of the physical aspects of the scenario – which are termed "physical fidelity," nor does it include realism as it pertains to logic, facts, sequences of events, and/or "if-then" relationships – which are termed "conceptual" or "semantic" fidelity (Dieckmann et al., 2007; Rudolph, Simon, & Raemer, 2007). The increase in phenomenal fidelity, as reflected in the new graduate nurses' comments, may lead participants of the simulation to easily "buy in" to the experience and quickly see how it relates to clinical practice (Dieckmann et al., 2007). Theoretically, this might imply an increased uptake in knowledge transfer when participants return to their everyday practice. However, research on this has been inconclusive (Dieckmann et al., 2007).

Scholarly research on the impact of stress on performance dates to 1908 when Yerkes & Dodson found that levels of stress (in rats) impact performance in an inverse U-shape: when levels of stress are both low and high, performance decreases. On the other hand, moderate levels of stress lead to increased and peak performance (Yerkes & Dodson, 1908). These findings have since been shown to be true in many different areas of human performance, from adolescent and adult math skills (Wang et al., 2015) to medical education (Koens et al., 2005). Most appropriately for our study, the Yerkes-Dodson law has also been documented in Nursing and Physiotherapy students (Sarid et al., 2004). What the new graduate nurses in this study were describing and experiencing in relation to "good stress" is likely related to this concept.

Patient family partners and simulated patients

The confusion and overlap of the patient family partner and simulated patient roles expressed by all participant study groups – new graduate nurses, patient family partners, and clinical educators – is both new and old. It is "new" in the sense that, to date, there has been no published research which explores participants' views of simulation-based education which employs *both* patient family partners and simulated patients. On the other hand, the confusion is "old" in the sense that it is not unique – within the realm of literature on patient engagement, there is no consensus on how to define a "patient" – whether it implies a person who has had a significant amount of involvement accessing health care, or whether it could be an ordinary citizen who has had infrequent use of the healthcare system. This issue of definition is raised in World Health Organization's report on Priority Medicines for Europe and the World Update 2013 (Kaplan, Wirtz, Mantel, & Béatrice, 2013):

> …how should patients and citizens be distinguished between? While there is widespread belief that values for health states differ between patients and the general public, there is a long-standing debate among health economists about the evidence to support this belief. … In general, it seems that patient and citizen involvement can be captured by the term 'public involvement' in many but not all cases. For a start, patients and citizens may have competing or contrasting interests in priority setting… Second, there are circumstances that call for a more specific use of experience. This is the case when involvement is sought with the explicit aim of seeking to use the experiential knowledge of a patient, or a well-described group of patients or care takers (p. 208).

Based on the above, the question that should be asked whenever employing public engagement in healthcare education is whether the engagement has a specific and "explicit aim" which necessitates the use of "the experiential knowledge of a patient" (Kaplan et al., 2013, p. 208). Furthermore, in healthcare simulation, the question should also be posed as to whether the experience of the simulated patient within the scenario is considered "authentic" and experiential enough for the purposes of the educational experience, or whether – due to the simulated patient's response being "acted" and semi-scripted – it is not considered credible by participants.

Regardless of whether future simulation-based education sessions promoting patient- and family-centred care choose to employ simulated patients and/or patient family partners, the reasons for including each should be clearly outlined and evaluated by those developing the education. The simulated patient literature to date does not, as far as the author is aware, describe whether simulated patients have previous, significant experience with the healthcare system, nor does it describe why or how particular actors are selected for simulated patient roles. Hopefully this is changing – a new article published in February 2020 explores the perspectives of simulated patients, and reports that simulated patients:

> …seek to authentically stand as a proxy for health care seekers, consider educational principles informing student learning, and feel responsible for assessing aspects of students' competences to practice (such as communication and empathy). Simulated patients believe that they portray the perspectives of health care seekers, which are different to those of health professionals. From the simulated patients' perspective, the patient perspective is essential to student learning and assessment. (Pritchard, Denning, Keating, Blackstock, & Nestel, 2020, p. 23)

How patients who *have* significantly experienced the healthcare system feel about simulated patients giving feedback as a proxy representative has not been explored; simulated patients themselves "acknowledge that their own experiences might not be relevant" to what they are portraying (Pritchard et al., 2020, p. 24). More exploration on these topics is warranted.

Co-debriefing, relational respect, and maternalism

The comments made by clinical educators related to the challenges of co-debriefing reflect the complex nature of simulation and debriefing and confirm what Cheng et al. (2015) have previously presented as challenges of co-debriefing. These

challenges include the experience of uncertainty, perceived misalignment of learning objectives, and differing personal agendas between co-debriefers expressed by the clinical educators (Cheng et al., 2015). The experience described by a patient family partner of not having their expertise appreciated, which may have been caused by the unfamiliarity between co-debriefers, has also been a previously suggested challenge of co-debriefing by Cheng et al. (2015).

Interestingly, in Díaz-Agea et al.'s (2017) previous study of simulation-based education for undergraduate nurses in Spain, no challenges or barriers related to the inclusion of real patients as co-debriefers was documented beyond the training of the real patients for co-debriefing. Notably, the study's two primary forms of data collection were through observation of the simulation debrief, and via surveys whose respondents were students only. Although one of Díaz-Agea et al.'s research questions was "How do the educator and the patient engage in co-debriefing?" (2017, p.406), conclusions to this question were drawn purely from observation of the debrief, and not by directly asking each party about their experience. Furthermore, there was only one educator who co-facilitated the debriefings, meaning that consistency and familiarity with the simulation was much higher for the one educator than for the multiple clinical educators who took part in this study. Also, from the description of how debriefs unfolded in the undergraduate program, it appears as though they were quite different from those of this study: in Díaz-Agea et al.'s (2017) context, students seemed to lead the majority of the debrief, with real patients doing most of the talking, while the educator/facilitator managed student questions and moderated the discussion. On the other hand, in this study's debriefs, the clinical educators typically led the debriefs and asked the most questions to stimulate conversation. Through their observations, Díaz-Agea et al. (2017) concluded:

> The facilitator and the patient complemented each other in the co-debriefing harmoniously. There were no contradictions or overlaps in the information provided to the students or the evaluation of their actions…There were no situations of tension or rivalry among patients and educators in the handling of information during the development of co-debriefing (p.409).

As this study did not include direct observation of the debriefs, it cannot be confirmed with utmost confidence that the same can be said of how the patient family partners and clinical educators interacted while co-debriefing. However, from the comments that new

graduate nurses shared in their interviews about the relationship between patient family partners and clinical educators, it seems reasonable to conclude that from an outsider standpoint, relational respect and alignment of objectives were likely what was observed by the new graduate nurses – even as some clinical educators did not inwardly experience this alignment.

Another phenomenon related to co-debriefing that is not well-described in the literature is the anxiety felt by the clinical educators. It is generally known that novice debriefers experience discomfort during debriefing (Krogh, Bearman, & Nestel, 2016; Rudolph et al., 2014, 2006) but the reasons *why* have not been subject to much study. When Rudolph et al. (2006) first introduced the concept of psychological safety in healthcare simulation and proposed that "Instructors often avoid giving voice to critical thoughts and feelings because they worry that criticism might lead to hurt feelings or defensiveness on the part of the trainee" (p. 49), the simulation community sat up and took note. The importance of psychological safety can be inferred by Rudolph et al.'s (2006) seminal paper being cited in 697 manuscripts as per a Google Scholar search (performed March 12, 2020) and its emphasis in other widely read simulation articles related to debriefing (Kolbe et al., 2019, 2015; Rudolph et al., 2014; Sawyer et al., 2016). However, psychological safety as it pertains to *instructors'* worry of criticizing learners has not been explored. This present study suggests that the worry felt by instructors may pertain to misaligned objectives between co-debriefers, and the challenges of maintaining psychological safety for learners within the debrief. These challenges may also be compounded by a sense of maternalism on the part of clinical educators. In the existing literature, the only relevant findings the author was able to discover about the experience of discomfort related to debriefers was in Krogh et al.'s 2016 qualitative study of debriefing practice. One of the identified themes in their study was the development of debriefers, with a component being:

> ***Becoming comfortable with the uncomfortable.*** Through experience and experiment, most of the interviewees reported becoming more comfortable with the learners' reactions to tricky situations and not knowing where the debriefing is going…. *"Accept that we will never become fully comfortable with the whole process no matter how many years' experience you get" Interviewee #24* (p.7)

This quote will help contextualize the recommendations of this study related to training and skill for co-debriefing with real patients (patient family partners). Although not

outlined in the original research questions, the themes constructed from the data and the existing evidence in the literature suggest that co-debriefing with real patients is a challenging skill for clinical educators to master. This experience can result in stress related to uncertainty – uncertainty of the co-debriefer's personal agenda and uncertainty as to whether a psychologically safe space can be maintained for students. There is hope, however: multiple participants in this study pointed out the benefits of co-debriefing with the same co-facilitators over time, and literature hints at experienced simulation facilitators learning to rest in the discomfort of the unpredictable (Krogh et al., 2016). As such, we recommend that those clinical educators who are presently or who are considering in the future co-debriefing with real patients consider the "Implications for Practice" described in Chapter 6 of this paper.

5.1.2. Related to Patient- and Family-Centred Care and Patient Engagement

Benefits and uncertainties

The remarks made by new graduate nurses and patient family partners surrounding the benefits of patient family partner inclusion in co-debriefing mirror the larger body of literature related to patients as teachers in general – mainly, that education sessions which employ patient-teachers have a positive influence on both learners and patients (Haq, Fuller, & Dacre, 2006; Humphrey-Murto, Smith, Touchie, & Wood, 2004; Jackson, Blaxter, & Lewando-Hundt, 2003) and that their presence increases authenticity in the learning environment (Henriksen & Ringsted, 2011). As in Díaz et al.'s (2017) study, survey results from the new graduate nurses indicate that the inclusion of real patients in co-debriefing is viewed favourably in dimensions of empathy, learning, and patient- and family-centred care.

On the other hand, not everyone agreed that real patients as co-debriefers was beneficial – there were participants whose opinion was lukewarm or indifferent. Unfortunately, due to the small number of comments explaining why some participants were neutral to the inclusion of patient family partners in co-debriefing, it is difficult to draw any firm conclusions from these responses. It is evident, however, that the responses provided by new graduate nurse Participants 26 and 36 (Section 4.2.2.) relate specifically to the educational method of simulation: Participant 36's statement is only possible when simulated patients are involved, and Participant 26's response is specific

to debriefing and possibly, the performative nature of simulation. New graduate nurse Participant 11's response, on the other hand, is a much more general statement about the inclusion of patient-teachers and reflects some of the unanswered questions about patient and family engagement at large. As Kaplan et al. wrote:

> …the validity of patients' experiential knowledge in the context of biomedical research processes raises questions: To what extent is the experienced perception of a patient representative credible? … (How) can one representative account for the perspectives of citizens with a variety of social and cultural backgrounds? (Kaplan et al., 2013, p. 209)

This quote also captures the remarks of clinical educator Participant 3a, who mentioned:

> Now this is a PFP, patient family partner, they have experience in healthcare… But what does that mean? …do [they] have any legitimacy? …we don't know…what their healthcare story is. We assume they have one, and I don't even know if people are aware that they have a healthcare story. I don't know any of their backgrounds myself, so when they talk I'm like, well did you have a couple of blood tests and that's what you're basing it on? Or were you hospitalized for three months and have a really thorough picture of what healthcare looks like? I don't even know… (Participant 3a, clinical educator focus group)

Upon seeing these results, one of the patient research partners involved in this study commented that this is a common theme in patient engagement: how "qualified" does a patient family partner have to be in order to be given that title and seen as an expert in the experience of receiving care? As previously discussed in this paper, this question is especially pertinent in simulation-based education, whereby simulated patients are often employed, and deserves more attention both at large and within the context of simulation-based education.

Considering all of the above with regard to the benefits and uncertainties associated with the inclusion of real patients as co-debriefers, it appears that the inclusion of real patients in co-debriefing is generally seen as beneficial by participants – in this case, new graduate nurses. However, more research is needed to better explore the reasons why some new graduate nurses are unsure about this.

Clinical educators' opinions on working with real patients

Very few studies exist which explore the opinions of health professionals who partner with patient-teachers (Towle & Godolphin, 2013) – let alone studies specific to the opinions of clinical educators. In the present study, clinical educators expressed that

partnering with patient family partners positively resulted in an ability to embody and role-model the values of patient- and family-centred care. They also appreciated that patient family partners provided feedback to new graduate nurses from a place of authenticity and lived experience (see Section 4.2.1). These same outcomes of health professional and patient-teacher partnership have previously been documented (Jha et al., 2009b; Towle & Godolphin, 2013). On the other hand, what Participant 5a expressed about their own, *personal* learning from working with patient family partners has not previously been reported. Existing literature has focused on the benefits of patient-teachers to the targeted learners within education sessions but has not explored how the inclusion of patient-teachers contributes to educators' *own* learning and beliefs. As this too can be considered continuing professional development of healthcare professionals, it merits further investigation.

With regards to patient engagement: while clinical educators respected the patient family partners and the concept of patient- and family-centred care at large, a third questioned whether simulation was the right venue for its application. As an experienced and knowledgeable simulationist, the author of this paper has interpreted those clinical educators' experience of uncertainty to be most aligned with the general unease caused by co-debriefing with anyone unfamiliar – not just as it relates to patient family partners. This however, may not be the case. Patient engagement in the realm of continuing professional development is nascent (Johnson et al., 2008; Nestel & Kneebone, 2010; Towle & Godolphin, 2013), with virtually no evidence-informed guidelines in existence. Johnson et al.'s 2008 publication on patient- and family-centred care, in which a chapter is dedicated to educating health professionals in a patient- and family-centred manner, is full of recommendations and examples but only has references to three studies related to continuing professional development provided by patients and families. More research is needed to draw any conclusive evidence.

Patient engagement in continuing professional development

Although patient and family engagement in continuing professional development falls under the "Collaboration" pillar of the patient- and family-centred care principles (British Columbia Ministry of Health, 2015; Institute for Family-Centered Care, 2017), results from this study indicate that all four of the core concepts of patient- and family-centred care (Section 2.1) have a place within this type of activity.

The principle of “Respect and Dignity” is highly applicable when working with patient-teachers, as evidenced in the comments made by both clinical educators and new graduate nurses. It is clear that in the experiences reported here, clinical educators were listening to, honouring, and respecting the voices of the patient family partners.

“Participation” is another of the core principles of patient- and family-centred care. What level of participation patients and families would like to engage in varies according to context (British Columbia Ministry of Health, 2015; Canadian Institutes for Health Research (CIHR), 2014; Patient Voices Network, n.d.). Differing levels of involvement are commonly described using the IAP2 Spectrum of Public Participation (2018) (Section 3.1.3.). From this lens, feedback from the two different patient family partner participants regarding what drew them to volunteer as co-debriefers (Section 4.2.1.) suggests differing levels of participation within the same education session. It seems as though Participant X was *involved* in the education process – whereby their feedback was being consistently heard, understood, and considered – whereas Participant Y was more of a *collaborator* with the clinical educator – a partner who was formulating solutions, developing alternatives, and pointing out preferred methods of engaging with patients in order to, as they describe, “shape the medical field.”

Admittedly, applying the IAP2 Spectrum of Public Participation (2018) to patient engagement within education is a process and has not previously been documented (to the author’s knowledge). The Spectrum itself is written from a decision-making point of view and has, to date, primarily been used to describe patient and family engagement in the realm of decisions related to patient care. However, it can be argued that differing levels of participation are applicable within the many areas of collaboration in which patient and family engagement is now occurring, such as it is with patient-oriented research (Abelson, 2015; The PEIRS Project Team, 2018). More research and discussion needs to take place in order to establish a shared lexicon for this type of work. The World Health Organization itself acknowledges the haphazard use of language when it comes to patient and family engagement, stating that:

> Assessment of the impact of patient and citizen involvement is complicated by the way experiences are reported in the literature. … Concepts like consultation, representation, and expertise have been used interchangeably, with patient and citizen involvement variably defined and often poorly described. (Kaplan et al., 2013, p. 209)

Relatedly, the quotes from new graduate nurse participants 52, 19, and 25 (Section 4.2.1.) allude to new graduate nurses' beliefs about what level of patient and family engagement they would like to see healthcare embrace. Participant 52 appears to believe that patients are experts about the healthcare system experience, and we should therefore be improving our system according to their feedback – we should empower them. Participant 25 on the other hand, seems to approach patients and families as equal partners with everyone else involved in the healthcare experience, which sounds more like collaboration. Participant 19's comment highlights the individualized aspects of patient and family care but does not give us enough information to sort it into a participation category. All these comments highlight the fact that differing healthcare professionals have different beliefs and assumptions about how patient and family engagement should unfold. If one hopes to implement patient- and family-centred care in all aspects of healthcare, further study should examine healthcare professionals' beliefs about patient- and family-centred care.

The fourth core principal of patient- and family-centred care, "Information Sharing," may or may not be applicable to the findings of the present study. We did not receive any specific feedback related to how freely information is shared or perceived to be shared with patient family partners regarding the overall process of the workshop and its simulations. That being said, with regard to the simulation scenario itself it can be argued that information sharing is occurring, as patient family partners are present throughout the simulation and its debriefing. This presence and access to information is a part of the reason why some new graduate nurses felt uncomfortable during the debrief and/or worried about its effect on the trust between patient family partners and healthcare professionals.

This suggests that framing the four core concepts of patient- and family-centred care solely in the realm of decisions related to care may be limiting its usefulness. As patient engagement continues to expand into more realms of healthcare, it is likely worthwhile to consider broadening the scope of these principles to all patient engagement activities.

5.2. Research question findings

Here we will attempt to address the original research questions for this study. Answers will not be explained in depth as they have been addressed in earlier sections of this paper. The research questions motivating the study were:

- How do members from each role within a new graduate nurse clinical decision-making workshop describe the experience of working in a program with patient-centred simulation?
    - What are the perceived benefits and risks of working with, or of being, patient family partners in simulation-based education?
    - How do members within each role perceive the value of patient family partners in simulation-based education, both at large and within the narrower, lived experience of a new graduate nurse clinical decision-making workshop?
    - Are there similar findings between roles and if so, what are they?
- How do members from each role perceive the relationship between roles?

5.2.1. Perceived value: benefits, indifference, risks, and challenges

When asked broadly about the perceived value of patients as co-debriefers, most participants spoke of either the benefits, challenges, or the neutrality/indifference they felt about this intervention.

The perceived benefits of working with or of being patient family partners in simulation-based education have been described in section 5.1 of this paper, and far outnumbered the challenges or indifferences mentioned by participants. Benefits specific to the learner group – in this case, new graduate nurses – were:

- Increased phenomenal fidelity of the simulation
- Appreciation, consideration, and authenticity of, and empathy for, patients and families in healthcare
- A more complex and informed education session
- Role-modelling the application of patient- and family-centred care principles
- Increased insight into, understanding of, and feedback from the patient and family perspective

Reported benefits specific to patient family partners are listed below:

- Providing a sense of positive value and contribution to the development of new graduate nurses
- Feeling heard and accomplished in promoting patient- and family-centred care
- Having the impression that by improving the skills of new graduate nurses, patient family partners are impacting the community at large

The only reported benefit to clinical educators was learning from patient family partners. Unfortunately, clinical educators were not specific about what they learned.

Unsurprisingly, all groups made mention of the benefits to learners – that the feedback, insight, and perspectives provided by patient family partners benefitted the new graduate nurses. Both clinical educators and new graduate nurses saw the importance of role-modelling and living patient- and family-centred care principles.

The perceived risks and/or challenges related to working with real patients as co-debriefers seen in the data are:

- An increase in anxiety on the part of both new graduate nurses and clinical educators
    - For new graduate nurses, this anxiety was reported as being a positive due to its proximity with reality
    - For clinical educators, the anxiety was related to co-debriefing and the uncertainty of what patient family partners might say in the debrief, which could destroy psychological safety or be misaligned with the session's objectives
- Role confusion and overlap between patient family partners and simulated patients

Finally, there were new graduate nurse and clinical educator participants who had neutral and/or indifferent feelings related to the inclusion of patient family partners in co-debriefing – these were the minority.

The question of how members within each role perceived the value of patient family partners in simulation-based education, both at large and within the narrower, lived experience of the new graduate nurse CDM workshop, revealed positives for most participants. For the majority, this was their first encounter of patient and family

engagement in simulation. It is interesting that two of the six interviewed clinical educators were unsure of whether simulation-based education was the right venue for patient and family engagement and questioned whether it would be more effective in a more passive and traditional teaching/learning format such as storytelling or lecture. When this uncertainty was further explored, the author of this paper determined that the unease surrounding having patients are co-debriefers is more consistent with previously reported challenges related to co-debriefing in general (not just with patient family partners) than it is with previously reported challenges of patients as teachers.

5.2.2. Perception of relationships

There were no negative reports related to any of the relationships within the simulations of study. When asked about the relationship between patient family partners and clinical educators, the vast majority of new graduate nurses made comments about the benefits of including patients as co-debriefers. Both patient family partner study participants had only positive remarks to make about the relationship. Clinical educators on the other hand provided a different perspective and their remarks were varied. They all expressed respect for the patient family partners and recognized that they came with good intentions, but some struggled with the disparity in patient family partners' debriefing abilities. Some were neutral towards the relationship and kept it purely professional, while another was unsure as to whether a perception of hierarchy between patient family partners and clinical educators existed. Finally, others enjoyed working with each and every patient family partner they encountered. Clinical educators all agreed that relationships with patient family partners improved over time.

Importantly, no sense of hierarchy was seen or observed by any study participants.

Chapter 6. Implications for Practice

6.1. Patients as Co-Debriefers

Those who are considering the implementation of patient co-debriefers in healthcare simulation should be aware that the body of research evidence relating to this method of education is extremely limited. Although the use of patients as teachers has had generally positive outcomes (Henriksen & Ringsted, 2011, Haq, Fuller, & Dacre, 2006; Humphrey-Murto, Smith, Touchie, & Wood, 2004; Jackson, Blaxter, & Lewando-Hundt, 2003), the research specifc to the use of patients as co-debriefers is limited to Díaz-Agea et al.'s (2017) study and the findings presented in Chapter 4. Given the findings of the present research, and taking into account the referenced research in Section 5.1.1, it is recommended that at this time, clinical educators who are presently or who are considering co-debriefing with patients take into account the practice implications which follow.

6.1.1. The ultimate purpose or objective of including the patient voice in the debrief

As seen in the findings from Section 4.1.3 and as previously discussed in Section 5.1.2, there was significant perceived overlap between the role of the patient family partner and that of the simulated patient in the debrief. Members from each of the new graduate nurse, patient family partner, and clinical educator groups described significant similarities between the feedback and insights provided by the patient family partners and the simulated patients, to the point of confusing the two. Those who are planning education activities involving both real patients and simulated patients must carefully consider the objectives related to each role and identify whether it is worthwhile and/or necessary to have both roles present. If both will be employed, ensuring the difference between roles, responsibilities, intentions and objectives for simulated patient and patient family partner involvement should be made explicit to all parties present in the education session.

6.1.2. Who and/or what type of past experience is required to qualify as a "patient"?

Hand-in-hand with the previous point, prior to implementing simulation with patients as co-debriefers one should first determine whether the authentic, "*experiential* knowledge of a patient" (Kaplan et al., 2013, p. 209, emphasis added) is required to meet the session's learning objectives, or whether the thoughts and opinions of a simulated patient who has possibly only experienced a simulated version of the event is sufficient. Additionally, seeking input on how patients who do have experiential knowledge of the healthcare system perceive the work of simulated patients warrants further exploration (see Chapter 7).

6.1.3. Skill level of debriefers

It is generally agreed that debriefers should be knowledgeable, experienced, and skilled in facilitating simulation-based education prior to taking on the challenges of leading co-debriefing (INACSL Standards Committee, 2016a, Cheng et al., 2015). Only after debriefers have become "comfortable with the uncomfortable" (Krogh et al., 2016, p. 7) should they take on the role as lead facilitator in an interprofessional co-debriefing simulation. Co-debriefers should also be familiar with the common challenges of co-debriefing as described in the literature (Cheng et al., 2015) to aid in anticipation and mitigation strategies related to co-debriefing.

Orienting patient partners to simulation

The patient family partners involved in the workshop from which participants for this study were recruited had all attended a full day of orientation to key concepts in simulation-based education. Of note is that the orientation included and emphasized the importance of the following concepts: the basic assumption – which assumes that everyone participating in simulation is intelligent, well-trained, cares about doing their best and wants to improve (Center for Medical Simulation, n.d.) – the importance of maintaining psychological safety for learners, and that for the purposes of the particular simulations the patient family partners would be involved in, keeping to the scenario's learning objectives during the debrief was of importance.

Despite this orientation session, there were clinical educators in our study who heard feedback from patient family partners which they perceived to have threatened the psychological safety of the new graduate nurses. There were also clinical educators who felt as though the objectives of some patient family partners were misaligned with those of the simulation.

For these reasons as well as those described in Section 4.1, patients who engage in co-debriefing should undoubtedly undertake training and orientation to simulation and debriefing. They should also have multiple chances to practice debriefing, ideally with the same co-debriefer they will be working with during simulation-based education sessions (see below).

Limiting the overall number of facilitators

For familiarity both with content and between facilitators to increase, there must be opportunity for facilitators to work together. A large pool of facilitators equates to less frequent opportunities for co-debriefing pairs to work together, unless there is dedicated time for practice and review (see below).

Maintaining co-debriefing partnerships

Co-debriefers should be kept in the same pairs as much as possible to promote familiarity, increase professional rapport, and decrease uncertainty in the alignment of debrief objectives.

Dedicated time for practice and review

Ideally, co-debriefers should have dedicated time to practice and review debriefings together. This would increase familiarity and rapport between facilitators and allow each party to purposefully acknowledge each other's personal agendas and objectives related to the simulation-based education session. While review of a co-debriefing checklist (such as the one provided in Cheng et al., 2015) is beneficial, participants in the present study claimed it was of quite limited usefulness due to time constraints during the workshop in which the co-debriefing takes place. They also stated that the checklist paled in comparison to the lived experience of working with others. Allowing enough time for dedicated practice and review of debriefing with the use of a co-debriefing checklist would be ideal – both during the patient family partners'

orientation to simulation-based education, as well as during each new graduate nursing workshop where patient family partners and clinical educators come together.

6.2. Patient Engagement in Continuing Professional Development

For those looking to implement patient- and family-centred care in continuing professional development generally – and not necessarily in the context of simulation-based education – the key recommendation for practice resulting from this study is to utilize the four core concepts of patient- and family-centred care to guide and evaluate continuing professional development endeavors. Once again, the four concepts are Dignity and Respect, Information Sharing, Participation, and Collaboration. While these concepts have traditionally been used solely in the realm of decisions related to direct patient care, results from this study (see section 5.1.2.) indicate that these same concepts, together with the IAP2 spectrum of public involvement (2018) can be applied to patient- and family-centred care in continuing professional development activities, and may contribute to the creation of a shared and standardized lexicon for patient engagement across healthcare activities.

Chapter 7. Considerations for Future Research

As we move from “Implications for Practice” to “Considerations for Future Research,” topics are categorized by whether they most closely align with the existing body of work related to simulation-based education or with the literature related to patient- and family-centred care. Note that there is one question which ties these two concepts together: how much and what type of lived experience as a patient must one have in order to be considered an authentic patient voice? Though this question spans the chasm between simulation-based education and patient- and family-centred care, it is explored in section 7.1 due to its connection with simulated patients in the context of this study.

7.1. Related to Simulation

7.1.1. The experience of debriefing

Though there exists a large body of literature dedicated to simulation debriefing (Sawyer et al., 2016), there has been very little published about the experience of debriefing from the point of view of the debriefers. Section 5.1.1 of this paper discusses the anxiety felt by the clinical educators as they co-debriefed with patient family partners, and reflects themes found by Krogh, Bearman, & Nestel (2016) in their qualitative study of debriefing practice. The explanations provided by the debriefers for their feelings of anxiety – they feared threatening the psychological safety and overall trust of the new graduate nurses, they believed their co-debriefing partners’ objectives were misaligned, and a possible sense of maternalism – are new findings. More qualitative research needs to be done to reveal the experiences and beliefs surrounding debriefing practice, in order to validate and better understand the debriefing practice journey. Without this knowledge, the community risks ineffective and stagnant development of future simulation-based education facilitators (Krogh et al., 2016) which may result in not only ineffective learning and an aversion to simulation-based education on the part of the learners but also risks sub-optimal transfer of knowledge to direct patient care.

7.1.2. Co-debriefing

There are few studies whose primary topic is specific to co-debriefing – in fact, Cheng et al.'s 2015 article is the only one the author was able to find. Using the search term "co-debriefing" yielded a total of only eight healthcare simulation-related articles (as of May 27th, 2020) throughout the holdings of the Simon Fraser University Library.

As described in Sections 5.1.1 and 5.2, the findings of this study reflect many of the co-debriefing challenges outlined in Cheng et al.'s (2015) article: the preservation of psychological safety for learners and the misalignment of learning objectives and personal agendas between facilitators. Research specific to the benefits and challenges of co-debriefing should continue in order to first determine whether it is a worthwhile practice and if so, how it may best be implemented and practiced.

7.1.3. Real patients and simulated patients

Findings from Section 4.1.3 and the discussion in Section 5.1.1 about real patients (or "patient family partners" in the context of this study) indicate that although there is continued, considerable support for patient engagement at multiple levels of healthcare (British Columbia Ministry of Health, 2015; Conway et al., 2006; Johnson et al., 2008; Ocloo, Josephine; Matthews, 2016), consensus on who qualifies as a "patient" has yet to be reached (Kaplan et al., 2013). Without this determination it is both confusing and difficult for those who seek to represent the "authentic" patient voice to determine who to work with. While experts in patient- and family-centred care and patient engagement ought to determine an agreed-upon, basic definition of what constitutes a "patient" for the purposes of patient engagement – or indeed if it even aligns with the values of patient engagement to make such a determination – researchers might also consider studying whether there is a measurable and/or perceived difference in outcome between varying levels of experiential knowledge of patients engaged in various healthcare activities.

This determination is of particular importance with regards to patient engagement within simulation-based education due to its unique position of employing simulated patients. Though simulated patients are "committed to representing the perspectives of real patients," (Pritchard et al., 2020, p. 21) and there are simulated patients who work

with real patients to develop and perform more authentic representations of the patient experience (Nestel et al., 2010), consulting and collaborating with those who have considerable lived experience of the healthcare system at large and/or of the situation specific to that of the character the simulated patient is meant to portray is not standard practice for simulated patients. Nor is consultation with real patients even considered "best practice" – the Association of Standardized Patient Educators' Standards of Best Practice (Lewis et al., 2017) does not consider real patients anywhere within its pages. Though the question of simulated patients' authenticity in comparison to real patients' perspectives was first considered in the literature nearly ten years ago (Nestel et al., 2010; Nestel & Kneebone, 2010), the topic remains a virtually unexplored area of research to this day.

7.1.4. Maintaining trust in healthcare professionals

As described in Section 4.1.1., when participating in the simulations with patient family partners present, some new graduate nurses worried about the possible negative impact their simulation performance would have on the patient family partners. Specifically, they were concerned that should a new graduate's performance not go well, patient family partners might lose trust in healthcare providers in general. Presumably, underlying this belief is the notion that individual nurses are seen as representatives for an entire class of professionals; the individual represents the collective.

Interestingly, although one of the two patient family partners did indeed verbalize some concern (on their own behalf as well as simulated patients) over the performance of a few new graduate nurses, they also specifically pointed out that it was "those two or three" individual nurses with whom they were concerned, as opposed to the collective.

Related to these findings is the notion of the individual representing the whole; how new graduate nurses may be excessively burdened by the belief that any errors they commit will be held against the whole of their profession from the patient's point of view. As new graduate nurses already face an enormous and disproportionate amount of stress (Edwards et al., 2015; Jewell, 2013; Rush et al., 2013), where this belief originates from and whether it is based in truth are worthwhile ideas to explore.

Though there were a small number of participants who directly spoke to the idea of risking the trusting relationship between healthcare providers and patients through the performance aspect of simulation, this topic warrants further study. Nursing in particular places high value in the nurse-patient relationship, often citing it as “the foundation of nursing care” (Hagerty & Patusky, 2003, p. 145). Therefore, anything which might jeopardize this relationship deserves exploration. While the researchers in this study heard directly from new graduate nurses and patient family partners, eliciting feedback as well from simulated patients – individuals who are more consistently exposed to simulation – would be advised in future studies.

7.2. Related to Patient- and Family-Centred Care

Considerations for future research related to patient- and family-centered care and patient engagement at large are described below. Please note that although the question of how “qualified” or how much experiential knowledge a person must have in order to be considered an authentic patient voice is a question related to patient engagement at large, the topic has been explored in section 7.1 due to its relationship with simulated patients within the context of this study.

7.2.1. Continuing Professional Development and Patient Engagement

Although patient engagement has been endorsed and implemented across a variety of healthcare settings (Park et al., 2018), there are few studies which explore the opinions of health professionals who partner with patients as teachers (Towle & Godolphin, 2013). This study reveals that differing healthcare professionals have different beliefs and assumptions about how patient and family engagement should unfold. If one hopes to implement patient- and family-centred care in broader aspects of healthcare, further study should examine healthcare professionals’ beliefs about patient- and family-centred care.

In finer detail, the present study also reveals perspectives from clinical educators about patient engagement in simulation-based education (section 5.1.2.) – perspectives which have yet to be verified or discredited and therefore merit further exploration. The present study may provide a starting-place for future research in this line.

The impact of patient engagement on clinical educators themselves

Most existing studies related to patient-teachers discuss the impact patient- and family-centred care has on the learners (Haq, Fuller, & Dacre, 2006; Humphrey-Murto, Smith, Touchie, & Wood, 2004; Jackson, Blaxter, & Lewando-Hundt, 2003) but do not address the impact of patient engagement on those co-facilitating with patient-teachers (Towle & Godolphin, 2013). In the present study we saw at least one clinical educator who found great benefit in their *own* learning from working with patient family partners and another who appreciated the opportunity to role model patient partnership and engagement.

The relationship between clinical educators and patient-teachers

A variety of attitudes towards the clinical educator and patient-teacher relationship were documented in this study. While new graduate nurses and patient family partners expressed only positive remarks when asked about the relationship, clinical educators had differing opinions (see section 5.2). Some thought of the relationship in purely neutral and professional terms, while others displayed a sense of maternalism and positive rapport, and the topic of hierarchy was mentioned. More research exploring these varied attitudes is recommended in order to better understand and prepare others who seek to implement patient-teacher and clinical educator partnerships.

Teaching/learning activities best suited for patient engagement

As described in section 5.1.2, patient engagement in the continuing professional development sphere is a recent endeavor (Johnson et al., 2008; Nestel & Kneebone, 2010; Towle & Godolphin, 2013) with no agreed-upon guidelines in existence. Clinical educators in the present study expressed that they valued patient- and family-centred care, but some questioned whether simulation-based education was the best venue for it. As patient- and family-centred care expands to realms beyond direct patient care, more research exposing what implementation methods – including the role of the clinical educator and patient-teacher partnership – are best suited for successful patient engagement is needed.

7.2.2. Patient Engagement Beyond Direct Care and Research

As noted in sections 5.1.2 and 6.2, this study has applied the core concepts of patient- and family-centred care as well as the IAP2 spectrum of public involvement (2018) to the practice of continuing professional development. However, it is challenging to find documented, practical examples of this type of application outside of direct patient care and patient-oriented research. This may be due to the varied and haphazard use of language when to comes to patient and family engagement at large (Kaplan et al., 2013). If the public and patient engagement community wishes to continue advancing this movement in a coordinated and evidence-informed fashion, more research and discussion must occur in order to establish a shared lexicon for this type of work.

Chapter 8. Conclusion

This research responds to the call for patient-centred simulation featured in the 2018 International Meeting on Simulation in Healthcare Research Summit article (Arnold et al., 2018). Inquiring into the experience of working with patients as co-debriefers has led to findings related to simulation and co-debriefing, beliefs surrounding patient- and family-centred care, and relationships. Specific sub-themes derived from the data included the anxiety felt by the learners in a patient-clinical educator co-debriefed simulation-based education session, the challenges of co-debriefing experienced by clinical educators, the confusion and/or overlap in roles between “real” and simulated patients, the benefits and indifference related to in the inclusion of real patients in simulation-based education, respect in relationships and the maternalism found in clinical educators.

There are many potential implications for practice stemming from this research. A key suggestion for those planning to implement patient-directed simulation is to clearly determine the ultimate purpose or objective of including the patient voice before deciding to what extent an authentic, lived experience of the healthcare system is required on the part of the “patient” to achieve those goals. Including enough time for co-debriefers to build rapport and trusting relationships between each other is also strongly recommended.

Areas of future research revealed by the present study relate both to simulation-based education and patient- and family-centred care. The call for more research related to patient-centred simulation remains open and is reflected in the findings. The literature surrounding co-debriefing as well as exploration into the perspective of the debriefer also remains sparse. Similarly, due to its novelty in areas outside of direct patient care, clear guidelines and an agreed upon lexicon in the realms of patient engagement continue to be beyond reach.

There is much that remains unknown about patient-centred simulation and patient- and family-centred care within the domain of continuing professional development. While this small study helps to fill some gaps, the author remains hopeful and excited to see what others will contribute to the domain.

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Appendix A. Survey for New Graduate Nurses

Below are the survey questions and Likert-scale scoring grid provided to New Graduate Nurse participants of this study:

Mark with an X the score that you consider most consistent with the opinion you have about the statement (1 = strongly disagree, 5 = absolutely agree)

Question	Score				
	1	2	3	4	5
The presence of actors as patients increases my learning of the simulated clinical situation					
The presence of real patients stimulates my learning of the simulated clinical situation*					
I believe that the knowledge the real patients convey is valid for my learning*					
The presence of actors as patients generated feelings of empathy and compassion for me					
The presence of real patients generated feelings of empathy and compassion for me*					
I have a better understanding of the care provided if I reflect with a real patient in the debriefing*					
I think the debriefing with real patients helps me consider the patient and family in my daily practice*					
I would recommend including real patients in clinical simulation scenarios*					

What did/do you appreciate (if anything) about having patient family partner as a part of the simulation experience?

What did/do you find challenging (if anything) about having patient family partners as a part of the simulation experience?

Do you have any comments about the relationship between patient family partners and healthcare educators, as you experienced it?

If you like, please draw something which represents what this experience was like for you:

Thank you!

* question has been replicated from Díaz-Agea et al.'s (2017) study, Patient-Oriented Debriefing: Impact of Real Patients' Participation during Debriefing. *Clinical Simulation in Nursing, 13*, 405-413.

Appendix B. Survey for Patient Family Partners and Clinical Educators

Below are the survey questions and Likert-scale scoring grid provided to Patient Family Partner and Clinical Educator participants of this study:

Keeping the context of the New Grad Nurse Clinical Decision-Making workshop in mind, pleas mark with an X the score that you consider most consistent with the opinion you have about the statement (1 = strongly disagree, 5 = absolutely agree)

Question	Score				
	1	2	3	4	5
The presence of actors as patients increases learning of the simulated clinical situation for new grad nurses					
The presence of real patients stimulates learning of the simulated clinical situation for new grad nurses *					
I believe that the knowledge the real patients convey is valid for learning for new grad nurses *					
The presence of actors as patients generated feelings of empathy and compassion for new grad nurses					
The presence of real patients generates feelings of empathy and compassion for new grad nurses *					
New grad nurses have a better understanding of the care provided if they reflect with a real patient in the debriefing*					
The debriefing with real patients helps new grad nurses consider the patient and family in their daily practice*					
I would recommend including real patients in clinical simulation scenarios*					
I believe the relationship between patient family advocates and healthcare educators has been equitable and fair					
I think the benefits of including real patients are not worth the risks					
I have been comfortable with the patient family partner-healthcare educator relationship in my experiences of this workshop					

What did/do you like about having patient family partner as a part of the simulation experience?

What did/do you find challenging about having patient family partners as a part of the simulation experience?

Any comments about the relationship between patient family partners and healthcare educators?

Please draw something which represents what this experience was like for you.

Thank you!

* question has been replicated from Díaz-Agea et al.'s (2017) study, Patient-Oriented Debriefing: Impact of Real Patients' Participation during Debriefing. *Clinical Simulation in Nursing, 13*, 405-413.

Appendix C. Simulation scenario overviews

The workshop in which the study participants took part had two separate simulation scenarios. Within one workshop, new graduate nurses would experience both simulation scenarios. Clinical educators and patient family partners (and simulated patients) on the other hand, would only be exposed to one scenario per workshop. However, clinical educators and patient family partners were trained to be able to facilitate both scenarios and over the course of multiple workshops would have experienced both. The reason they were only privy to one scenario during each workshop was because the new graduate nurses were split into two groups to achieve a smaller, more intimate education setting. Scenarios ran concurrently and back-to-back, with each half of the new graduate nurses experiencing separate scenarios, and then they would switch.

Each scenario includes:

- One clinical educator who facilitates the simulation from beginning to end. They provide orientation to the simulation scenario, observe during the simulation, and co-debrief after the simulation scenario is over.
- One patient family partner who observes until the simulation scenario is over, and then co-debriefs with the clinical educator.
- Two simulated patients (actors) – one who acts as the patient in the simulation scenario and one who acts as the patient's family member in the simulation scenario. These simulated patients observe during the simulation scenario orientation, take active part in the simulation scenario itself, and are then invited to share their opinion by a co-debriefer (either the clinical educator or the patient family partner) during the debrief.
- New graduate nurses – a few new graduate nurses take active part in the simulation scenario, while the remainder observe. All new graduate nurses are meant to actively listen throughout the simulation and to participate in the debrief.

Scenario A is an acute care scenario which takes place in a simulated hospital setting. One new graduate nurse is given a script (New Graduate Nurse A) – New Graduate Nurse A begins the scenario by hanging and administering an intravenous medication for a patient (Simulated Patient W, who is an actor) and subsequently gives handover report to the nurses who will be providing break relief. Nurse A then proceeds to go on break. The nurses who are providing break relief are New Graduate Nurse B and New

Graduate Nurse C. Shortly after New Graduate Nurse A departs, the patient rings the call bell and states they are feeling unwell – they're having a hard time breathing and are itchy. The patient will proceed to have the beginnings of an anaphylactic reaction to the intravenous medication. New Graduate Nurses B and C are to respond to this scenario and may ask for help from other new graduate nurses if they feel it is necessary. Partway through the scenario, the patient's "sister" (Simulated Patient X, another actor) will arrive, worried about what is happening. Nurses B and C are to tend to both the patient (Simulated Patient W) and the patient's sister (Simulated Patient X) until the scenario is complete.

Scenario B is a community care scenario which takes place in a simulated home environment. New Graduate Nurses D and E are taking part in a home care visit to a patient (Simulated Patient Y, an actor) and his wife (Simulated Patient Z, an actor). This will be the first home care visit the patient and his wife have had since returning home from hospital. New Graduate Nurses D and E are to complete the initial home care visit and perform a thorough assessment of the patient, including listening attentively to both the patient and his wife's concerns, questions, and preferences, and tailoring the visit and home care plan to this particular couple's needs and motivations.

Table C-1. Simulation scenario overview

	Orientation	Simulation Scenario	Debrief
Scenario A: Acute Care	• Clinical Educator A gives information • Patient Family Partner A observes • Simulated Patients W and X observe • New Graduate Nurses listen	• Clinical Educator A observes • Patient Family Partner A observes • Simulated Patients W and X are in character, providing mostly scripted responses • New Graduate Nurse A is in character, providing a scripted introduction and then exits the scenario • New Graduate Nurses B and C are actively participating • All other New Graduate Nurses are actively listening and may or may not end up actively participating	• Clinical Educator A co-debriefs • Patient Family Partner A co-debriefs • Simulated Patients W and X provide feedback in debrief when invited to do so by Clinical Educator A or Patient Family Partner A • All New Graduate Nurses actively take part in debrief

	Orientation	Simulation Scenario	Debrief
Scenario B: Acute Care	• Clinical Educator B gives information • Patient Family Partner B observes • Simulated Patients Y and Z observe • New Graduate Nurses listen	• Clinical Educator B observes • Patient Family Partner B observes • Simulated Patients Y and Z are in character, providing mostly scripted responses • New Graduate Nurses D and E are actively participating • All other New Graduate Nurses are actively listening	• Clinical Educator B co-debriefs • Patient Family Partner B co-debriefs • Simulated Patients Y and Z provide feedback in debrief when invited to do so by Clinical Educator B or Patient Family Partner B • All New Graduate Nurses actively take part in debrief

Appendix D. Recruitment Materials

PARTICIPANTS WANTED!

Help shape the future of professional development in healthcare

Our research study seeks to explore the perspectives of three different roles involved in an innovative education method: the use of real patients as co-debriefers in the context of simulation-based education for professional development.

Using mixed methods, the authors hope to explore the lived experiences, relationships, and perceived benefits and risks resulting from this education method.

Eligibility:

- Have attended the simulation portion of the New Grad Clinical Decision-Making workshop
- Are either: a new graduate nurse, a patient family partner, or a healthcare educator
- Are living in the Greater Vancouver area

Participation in the study consists of:

- Answering a written survey, ~5-15 minutes
- Participation in a focus group, ~15-45 minutes
- Reading written results and providing feedback, ~5-20 minutes

Refreshments and snacks will be provided during focus group interviews. Focus group participants will also be reimbursed for their parking or transit costs.

Interested? For more information, please contact:

Christina Choung, Primary Investigator, RN: [redacted]

Kent Cadogan Loftsgard, Co-Investigator, Patient Research Partner: [redacted]

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Vancouver CoastalHealth

THE UNIVERSITY OF BRITISH COLUMBIA

Recruitment Email

Subject title: Patients as Co-debriefers: study recruitment

Dear Patient Family Partner,
Thank you for your participation in the Vancouver Coastal Health New Graduate Nurse Decision-Making Workshop! As a Patient Family Partner involved in the workshop, you are being invited to take part in a qualitative study which seeks to explore the perceived value of patients as co-debriefers in the professional development of healthcare staff. Please see the attached recruitment poster for more information.

If taking part in this study is something which would be of interest to you, please contact either of the co-investigators. Christina Choung is a RN and Simulation Educator, and Kent Cadogan Loftsgard is a Patient Research Partner affiliated with multiple organizations including the Patient Voices Network and the UBC Patient & Community Partnership for Education.

We appreciate your time and look forward to hearing from you.

Sincerely,
Christina Choung & Kent Cadogan Loftsgard

e-mail:
phone:

Appendix E. Semi-scripted interview guide

Below is the semi-scripted interview guide used for this study:

Welcome and thank you for participating in this interview. As a reminder, we're here to discuss the inclusion of patient family partners as co-debriefers in simulation-based education – specifically related to your experience with the CDM workshop.

This session will take about 30-60 minutes, depending on group size and participation. We'll be recording this session's audio. Please note that your responses will be anonymized – we as researchers will be assigning you research identification numbers. No one other than myself will know who's taken part in the study, as what you're saying now will be transcribed. The other researchers will only be able to read a copy of the discussion that takes place.

Any questions before we start with the official research questions?

- Within the context of patient-centred simulation, what has been your experience of working with patients as teachers/healthcare educators?
- What are your thoughts surrounding the inclusion of PFPs in the NGN CDM workshop?
- What effects do you believe patient family partners had on the NGN CDM workshop?
    - Prompts re: all roles: PFP, RCE, NGN:
        - What value/benefits do you believe having PFPs as co-debriefers brings to these simulation sessions?
        - What challenges exist with the inclusion of PFPs as co-debriefers in these workshops?
        - What risks exist with the inclusion of PFPs as co-debriefers in these workshops?
- How did you experience the relationship between the PFPs and healthcare educators?

Appendix F. Codebook

Table F-1. Codebook

Theme	Code	Definition	Examples from data
Findings specific to simulation and co-debriefing	Anxiety related to performance and maintaining trust in healthcare professionals	Any evidence of anxiety or stress increased by the presence of patient family partners, either during the simulation scenario or related to patient family trust in healthcare professionals	"I think that it's a little bit more intimidating but I think that it's also like, way more realistic. Because I think it's a little intimidating in real life when you have someone watching you [others nodding] in a situation, whether it's a crisis or not. And so I think it made the scenario feel much more real because you had that sort of, like, performance anxiety sort of [others laughing and nodding] because, like yeah, I feel like that made it real for me." -New Graduate Nurse "And we like, our eyes were like deer in the headlights, we couldn't believe what we had just witnessed of this unfortunate new grad who, who just didn't know what to do, and we, it kinda left me wondering like, what's the follow-up?... so those two or three who like, that have come through that, you know, just it's quite shocking that this person is actually a nurse at this point, it's kinda scary." -Patient Family Partner
	Challenges of co-debriefing	Any evidence of increased stress, anxiety, uncertainty, or added challenges related to the addition of patient family partners during the debriefing process	"I would say that the challenge is that it's unpredictable. And that remains consistent. Because it is, it tends to be variable patient family partners, and that's okay, but if they're new to it or haven't done it before my concern is that I never know what's going to come out of their mouths so … I do think consistency is consistently a problem." - Clinical Educator
	Confusion and/or overlap in roles between "patients"	Any evidence of confusion or overlap in role between real patients (who are patient family partners) and simulated patients (who are actors)	"I really am trying hard to put myself in the position of the patient, yet if the patient also has feedback to give the new hires, so that person, as an actor though, that's a great perspective too, because I've noticed that they really do have great feedback for the new grads. Those actors' feedback are really great. And they really do parallel very much with how my comments were often, how I would feel as the patient or the family member." -Patient Family Partner "…we also have two standardized actors, we have a family person in and we have a patient and a caregiver and that helps when we do the debrief to be able to not just talk about what the actions were with the patient in question, but how did we draw in the family member? So I think there are opportunities to do that in the debrief, personally, without having the patient family partner necessarily be there. I also want to add that I have done sessions where there hasn't

Theme	Code	Definition	Examples from data
			been a patient family partner and we've still been able to talk about patient and family-centred care." -Clinical educator
Beliefs surrounding patient- and family-centred care and the inclusion of patient family partners	Benefits of the inclusion of patient family partners	Any evidence of experienced or perceived benefits related to the inclusion of patient family partners	"I just think it's so important for us to learn from people with lived experience. I think we spend our whole time in nursing school learning about theory and from a textbook and this research says this and not a lot of research necessarily includes patient voices. And I think that that's just a huge, important thing to learn from – is people with actual lived experience. Um, because I think that's how we can make our healthcare system better – is like, they know the healthcare system the best." -New Graduate Nurse "I think having them [patient family partners] present really makes it obvious to us as facilitators and debriefers as well as the participants in the room just how important and valuable it is so people pick up on those patient and family centred care principles kind of cues maybe more so than they would in other situations." -Clinical Educator
	Indifference related to the inclusion of patient family partners	Any evidence of indifference or neutrality related to the inclusion of patient family partners	"I think that my last few sessions, it's not been horrible but it's also – I don't think it's [the inclusion of patient family partners] added [any value]." -Clinical Educator "It [the inclusion of patient family partners] didn't really add to the learning experience" -New Graduate Nurse
Relationships	Respect	Any evidence related to the respect between patient family partners, new graduate nurses, and/or clinical educators	"I think the relationship is quite good [between the patient family partners and clinical educators]. I haven't had any issues. We have great conversations. You know they're excited to be there and we're excited to have them there." -Clinical Educator "I mean, they [clinical educators] were always very, very polite and very grateful. Always expressed their thanks and thanked us at the end as well, and recognized us." -Patient Family Partner
	Maternalism on the part of clinical educators	Any evidence related to feeling responsible for, and making decisions in the self-perceived best interest of, another group	"The relationship is tricky in the room if the patient family partner is saying un-related and/or un-supportive things - the learners are my responsibility and the patient family partners are volunteers where what they say is unscripted and therefore unpredictable." -Clinical Educator